CHAPTER 32

Incentives for Physicians to Decrease Services

The U.S. is expected to spend over $10,000 per capita on health care in 2013. Total expenditures will be $3.3 trillion dollars, over 18% of the gross domestic product (1). Despite these expenditures, the United States continues to have worse infant mortality and life expectancy than other countries that spend less per capita on health care and provide universal health insurance. Eliminating inefficiency and waste will not solve the problem of rising costs because new medical technologies and an aging population will continue to drive them up (2,3). Although the goal of restraining health care costs is appropriate, the means employed might raise ethical concerns. The ethical guideline of justice requires physicians to be prudent because health care resources are limited. However, this ethical obligation might conflict with the obligation to act in individual patients' best interests. Patients do not want to forego beneficial care in order to save money for society or for insurers (4,5).

Many cost control measures used by managed care in the 1990s created conflicts of interest for physicians and undermined their traditional fiduciary role. Specific practices were

- Allowing patients to see only physicians in the plan
- Requirements that primary care physicians serve as "gatekeepers" to approve referrals to specialists
- Financial incentives to physicians, such as capitation, to provide fewer services
- Administrative measures, such as utilization review, practice guidelines, and restrictions on prescription drugs

Such pressures to control expenditures have been strongly criticized because the savings might be used to pay for salaries of executives and for dividends to shareholders in for-profit plans. A public backlash has led insurers to back away from these managed care tools. Excesses in early managed care have been eliminated, such as steep financial incentives to physicians to limit costs, cumbersome authorization processes, and gag rules to prevent physicians from disclosing options for care that the insurer did not cover.

This chapter analyzes how the self-interest of physicians and health care organizations might conflict with the patient's best interests. Chapter 30 analyzes the related issue of conflicts of interest between different patients.

CASE 32.1 Drugs not on preferred list.

Ms. R, a 64-year-old business executive, has diabetes and hypertension. Urine analysis shows microalbuminuria. Evidence-based practice guidelines recommend that she take an angiotension converting enzyme (ACE) inhibitor, which will lower her risk for renal failure. She sees an advertisement for a new ACE inhibitor that has once-a-day dosage and asks you if she should be on it. Under her insurance plan her copayments are $20 a month for generic drugs, $30 a month for preferred drugs on

the plan's formulary, and $60 a month for nonpreferred drugs. The advertised drug is a nonformulary drug; the patient would need to pay the full price of $200 a month.

Case 32.1 illustrates the current approach to restraining costs through increased copayments and deductibles so that patients have personal incentives to control costs (6–8). Because out-of-pocket expenses for prescription drugs have increased sharply, insurers have increased copayments and instituted tiered benefits. This approach resolves some conflicts of interests for physicians because both they and their patients have an interest in cost-effective care. However, cost-sharing also raises ethical concerns because it might discourage use of essential drugs and lead to worse outcomes for patients with chronic illness (9,10). Raising copayments deters the use of ACE inhibitors in plans that have multitier formulary systems (11). ACE inhibitors are expensive but prevent renal failure in patients with diabetes and proteinuria (11). Thus, for Ms. R, financial incentives in her insurance plan tend to compromise the quality of diabetes care. Consequently, patients commonly ask physicians whether it is worth paying more out-of-pocket for certain drugs (12). The physician can then play the role of advising the patient. No longer is the physician viewed as an agent of the insurance plan who is unwilling to prescribe newer and more expensive drugs.

ETHICAL CONCERNS ABOUT INCENTIVES TO DECREASE SERVICES

BENEFICIAL CARE MIGHT BE WITHHELD

Ideally, incentives to control costs lead physicians to eliminate services that offer little or no benefit to patients. However, physicians might also be encouraged to withhold interventions that provide substantial benefit, as in Case 32.1 (13–15).

Empirical evidence on how managed care affects the quality of care and health outcomes is inconclusive. Overall, outcomes seem to be similar in managed care and fee-for-service care (16,17).

Both physicians and the public believe that some forms of managed care compromise the quality of care (18–20). In one study 20% of physicians believed that gatekeeping has a negative effect on the overall quality of care, compared to 6% who believe that it has a positive effect (21). More specifically, 40% of physicians believed that gatekeeping has a negative effect on the appropriate use of specialist care. However, physicians also reported that gatekeeping improves coordination of care and preventive care. In another survey nearly 50% of physicians believed that formularies had a negative impact on the quality of care, but only 13% thought they had a positive impact (22). Such concerns might be greater in for-profit managed care plans, where savings might be reallocated to salaries for plan executives or for returns to investors.

Limits on interventions might be carried out unfairly. Patients who are socially privileged, who are more persistent in demanding services, or who are more skilled at gaming the system might be more likely to obtain desired interventions.

THE FIDUCIARY ROLE OF PHYSICIANS MIGHT BE UNDERMINED

Cost-containment measures might lead patients to question whether physicians are acting in their best interests. In one survey 61% of persons in heavily managed plans were worried that if they became sick the plan would be more concerned about saving money than providing the best medical treatment (19). In comparison, 51% of persons in less tightly managed plans and 32% of patients in traditional plans had such worries. In another study capitated patients had lower levels of trust in their physicians than fee-for-service patients (23).

Financial incentives to reduce costs might create conflicts of interest. Physicians might act in their own self-interest or in third parties' interest rather than in patients' best interests. Utilization review and practice guidelines might put physicians in the role of implementing policies set by administrators rather than acting as professionals who exercise independent clinical judgment. Furthermore, an emphasis on cost containment and efficiency leads physicians to become entrepreneurs focused on profits instead of healers focused on patient well-being (24).

RESPONSIBILITY OF HEALTH CARE ORGANIZATIONS FOR INCENTIVES TO DECREASE SERVICES

Health care organizations can eliminate or mitigate conflicts of interest in several ways (25).

USE ACCEPTABLE FINANCIAL INCENTIVES

As a means of reducing costs, incentives to physicians have advantages over guidelines or rules (26,27). Incentives allow physicians to exercise discretion and take into account the circumstances of an individual case. In addition, incentives avoid micromanagement and bureaucratic requirements for documentation. However, very direct and strong incentives to decrease services that involve a large percentage of the physician's income create an unacceptable risk that physicians will act contrary to patients' interests (28–31).

Increasingly, managed care organizations are using a blend of incentives. Physicians might receive a base salary, with adjustments for productivity, utilization, patient satisfaction, and quality of care (32,33). For instance, physicians might receive a bonus for ensuring that patients receive indicated preventive measures, such as screening mammography. Such balanced reimbursement systems encourage a strong doctor–patient relationship and quality of care as well as cost containment.

DISCLOSE ECONOMIC INCENTIVES TO PATIENTS

Managed care systems should disclose to enrollees their financial arrangements with physicians (34). Federal Medicare and Medicaid regulations require such disclosure, as do some state laws (29,35,36). Such disclosure need not reduce patient trust in physicians or insurers (37). Disclosure might benefit patients in several ways. It might help patients choose a physician, physician group, or plan. Knowing how physicians are reimbursed might help patients put physicians' recommendations into context and decide whether to appeal or pay out of pocket if coverage is denied. Most important, disclosure might deter problematic financial arrangements that would be difficult to defend in public.

ALLOW JUSTIFIED EXCEPTIONS TO GUIDELINES AND FORMULARY RESTRICTIONS

Even the best clinical guidelines or utilization review system cannot cover all cases appropriately. There might be circumstances that the guidelines did not anticipate or capture, or a case might have particular features that justify an exception (38). The physician is in a unique position to identify justified exceptions to general guidelines. Organizations need to allow legitimate exceptions. For example, insurance plans may limit the number of prescription drugs per patient that are covered. For patients with multiple chronic illnesses, these limits can lead to exacerbations of illness and increased use of emergency services (9). Hence, liberal exception policies are needed for patients at high risk for adverse outcomes. Health insurers also need to institute appeals procedures that are not unduly burdensome for physicians and patients. The ethical justification for practice guidelines and formulary restrictions assumes that physicians can identify patients for whom an exception is justified and that neither patients nor physicians are deterred from obtaining approvals for exceptions by a complicated authorization or appeals process.

In short, health care organizations can create an ethical climate in which incentives to limit services have a stronger ethical justification (39). First, there should be a means of reallocating saved resources to interventions that would provider greater benefits for the population of patients receiving care. Second, the physicians would not profit directly from saving resources. Third, the limitations in care are applied equitably to all similar patients, regardless of social status.

RESPONSES BY PHYSICIANS TO INCENTIVES TO DECREASE SERVICES

When an effective test or treatment is not covered by the insurance plan, the physician faces issues of disclosing the intervention, recommending it, and helping the patient obtain it (25) (see Table 32-1).

DISCLOSE OPTIONS TO PATIENTS

In Case 32.1 the patient asks the physician about a nonformulary drug. In other cases the physician must decide whether to tell the patient about services that are available outside the system, even if the plan will not cover them. On the one hand, physicians might fear that such disclosure will only make the patient angry and that they will be the target of that anger. On the other hand, the ethical guidelines of autonomy and beneficence require physicians to discuss alternatives that might offer significant clinical benefits to patients. If patients are not informed of alternatives outside the managed care system, they cannot try to obtain them or make informed decisions about their care. Patients might try to convince the plan to pay for care outside the system, pay out of pocket for care, or postpone care until they can change insurance plans.

RECOMMEND OPTIONS THAT PROVIDE SIGNIFICANT CLINICAL BENEFITS

The physician should recommend out-of-plan options that provide clinically significant benefits over care available in the plan. Recommendations should take into account published evidence, clinical judgment about the individual case, and the patient's values.

Physicians also might be legally liable if, against their medical judgment, they withhold beneficial care at the insurer's behest. In a case involving premature hospital discharge, one court declared, "the physician who complies without protest with the limitations imposed by a third-party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care (40)."

Acting in the patient's best interests is not an absolute duty. Physicians have no ethical obligation to order or provide interventions against their medical judgment. Moreover, physicians should not recommend or order an intervention when another option has a more favorable balance of benefit to risk. The term "benefit" needs to be interpreted broadly in order to include psychosocial variables as well as biomedical outcomes. For some patients convenience in taking medications, reassurance about not missing a serious diagnosis, or rapid recovery to full function are extremely important.

It is ethical for physicians to take into account the cost of care when several approaches have similar outcomes for patients. When the ethical guideline of beneficence provides no strong reason to recommend one option over another, the guideline of justice might then be decisive. The prudent use of limited health care resources might be an acceptable reason to choose one of the options. In Case 32.1 it is appropriate to use preferred drugs that require multiple daily doses rather than more expensive, equivalent drugs in the same pharmaceutical class. Physicians and patients need to acknowledge that such decisions are a form of bedside rationing (41) but recognize that they can be ethically appropriate. Physicians should be willing to discuss these issues openly and honestly with patients (39).

It might subsequently become apparent that the preferred drug fails to benefit a particular patient. The patient might have an unsatisfactory outcome, unacceptable side effects, or find it impossible to take several doses a day. These adverse outcomes justify trying the more expensive drug.

ACT AS PATIENT ADVOCATE

The guideline of beneficence urges physicians to act as advocates to intercede for or speak on behalf of patients (25,42). Advocacy should be based on sound clinical judgment and evidence. It is not doing whatever the patient requests. Advocating for a patient is fair only if it would also be appropriate for other physicians to advocate for patients in similar situations. In Case 32.1 the physician would not be justified in requesting coverage for the nonformulary drug if the patient is doing well on the current drug. Physicians need to make reasonable efforts to help patients obtain authorizations or make appeals to obtain care. Such efforts might include filling out forms and making phone calls.

AVOID DECEPTION

Physicians sometimes use deception to obtain insurance coverage for a patient. In one survey 39% of physicians reported that during the past year they had exaggerated the severity of a patient's condition, changed a patient's billing diagnosis, or reported signs and symptoms the patient did not

have in order to help the patient get needed care (43). Such deception is more common when physicians believe that it is unfair for the plan not to cover the intervention, when they believe that the insurer's appeals process was unwieldy, and when the patient's condition is more serious (44). However, avoiding deception is a basic ethical guideline that serves to limit obligations to serve as patient advocates (42). Lying and deception undermine social trust because people cannot trust that other statements are truthful. Chapter 6 argues in detail that deception of insurers is not justified, except as a last resort after appeals have failed (25).

PATIENTS' REQUESTS FOR INTERVENTIONS THAT PHYSICIANS BELIEVE ARE INAPPROPRIATE

Such requests might occur in any system of health care but might be more acrimonious in managed care.

CASE 32.2 Patient requests medically unwarranted diagnostic tests.

A 26-year-old man receiving care in a health maintenance organization (HMO) has mild occipital headaches without any other symptoms for 2 weeks, associated with a period of increased stress at work. Heat or acetaminophen promptly relieves his headaches. His examination is remarkable only for mild trapezius spasm. His neurological examination is normal. He insists on a magnetic resonance imaging (MRI) scan to be sure that he does not have a brain tumor. He also wants a referral to a neurologist. The physician believes that the patient has tension headaches and that further workup would not be indicated. The patient exclaims, "You're just trying to save money for the HMO!"

The key ethical issue in this case is whether the MRI scan or neurology referral would benefit the patient. The likelihood of finding a serious intracranial lesion is so low in this case that an MRI or referral would not be recommended, even under fee-for-service reimbursement. The mere possibility that the headaches might be caused by a serious intracerebral lesion does not justify scanning or referral at this time. Anecdotal reports of patients who had a brain tumor discovered on an MRI for headaches should be regarded simply as anecdotes, not as persuasive evidence of effectiveness. It is ethically appropriate for the physician to follow practice guidelines or utilization review restrictions that disallow the test or referral (Table 32-1). Indeed, it might be less stressful for physicians to say that insurer will not cover the test or referral.

Rarely, a patient might be so worried about having a brain tumor that the patient's everyday activities are compromised. In this situation it might be appropriate to order an imaging study or referral for reassurance and to appeal a utilization review denial. However, the test should be part of a comprehensive plan of care that would also include counseling to address the patient's fears of cancer.

How can the physician respond to the patient's charge that the physician is merely trying to save money for the system (45)? First, the physician should explore the patient's concerns and acknowledge the uncertainty of medical diagnosis. Also, the doctor should explain to the patient why these interventions are not recommended at this time. The physician should arrange to see the patient

TABLE 32-1

Responses by Physicians to Incentives to Decrease Services

Disclose options to patients.
Recommend options that provide significant clinical benefits.
Act as patient advocate.
Avoid deception.

again in case the headaches do not resolve satisfactorily. In addition, the doctor should leave open the possibility of imaging studies or referral in the future if needed.

In summary, within the constraints of health care plans, physicians need to act as patient advocates when the patient could receive significant clinical benefit from a referral, test, or therapy that the plan disallows. In addition, financial incentives that are highly likely to lead physicians to order medically inappropriate care need to be identified and limited.

APPENDIX: COST-CONTAINMENT MEASURES IN MANAGED CARE

The term "managed care" covers a variety of organizational features (46). Managed care systems include HMOs and preferred provider organizations (PPOs) (47). Patients in HMOs select a primary physician or physician group and must obtain covered services through them. HMO physicians contract to provide comprehensive medical care for capitated payments, which are a fixed amount per patient, regardless of the actual costs of care. A few HMOs are staff or group model HMOs, with a closed panel of physicians working primarily for the HMO. Other HMOs are less tightly organized independent practice associations (IPAs), which contract with physicians or physician groups to provide services. A physician or group might belong to several competing IPAs.

In PPOs "preferred" physicians and hospitals accept discounted fee-for-service reimbursement rates and administrative controls in exchange for a flow of patients. PPO patients might also visit nonpreferred providers in the network, but at additional cost.

Point of service (POS) plans allow still greater choice of physicians or hospitals for higher premiums. Out-of-network care is still covered, but less completely and with higher copayments.

We discuss here how managed care systems try to control health care expenditures through gatekeeping, financial incentives, and administrative measures.

THE PHYSICIAN AS GATEKEEPER

In many managed care systems primary care physicians serve as gatekeepers who must approve referrals to subspecialists or hospitalizations for them to be reimbursed. Gatekeepers might be financially at risk for the costs of care for their panel of patients.

Gatekeeping restrictions are unpopular with patients and physicians alike (48). Demands for "freedom of choice" of physicians have led many plans to modify strict gatekeeping. Direct access to some specialists, such as gynecologists, is common and even mandated in some states. Some insurers are offering plans that provide unrestricted access to specialists (48).

FINANCIAL INCENTIVES TO PHYSICIANS

Managed care plans might offer physicians a range of incentives to practice cost-effective medicine (31).

Capitation

Plans may pay primary physicians or physician groups on a capitated basis. The provider receives a fixed amount per patient enrolled, regardless of how often the patient visits.

Salary

Salary is common as a base reimbursement in staff-model HMOs and in large physician groups. Both salary and capitation provide a financial incentive to limit the amount of health care provided and to avoid more complicated patients.

Bonus and Withhold

Primary care physicians might also be financially liable for excessive expenditures (14,28,31). The managed care plan might withhold part of the primary care physician's capitated payments, and, if expenditures are high, the plan might keep the withheld funds. Alternatively, some plans give gatekeepers a bonus if expenditures for specialty care or hospitalizations fall below a target level.

Balanced Incentives

Increasingly, physicians also receive bonuses for patient satisfaction, adherence to prevention and chronic care guidelines, and other measures of quality of care (32,33,47). These quality incentives counterbalance incentives to provide fewer services.

Typical bonuses range from 5% to 10% of net income (32). When more of the physician's income is at stake, concerns about conflicts of interest intensify.

Incentives that a managed care plan presents to a physician group might differ from the incentives the group presents to the individual physician. Physicians also commonly face various incentives from different insurance plans and might not know the details of reimbursement for any particular patient.

ADMINISTRATIVE MEASURES TO CONTROL COSTS

In addition to financial incentives, managed care systems use a variety of administrative measures to control costs. Most fee-for-service plans also use some of these techniques.

Utilization Review

Such programs include prior authorization, concurrent review, discharge planning, and case management for high-cost patients (49). They are intended to discourage physicians from providing unnecessary or marginal services. However, some utilization review procedures might disallow interventions that physicians consider medically necessary and beneficial to patients (18,50).

Practice Guidelines or Protocols

These specify how physicians should act in certain circumstances (26). They may limit inappropriate use of specialists or diagnostic tests, correct underuse of beneficial interventions, and reduce unjustified variations in practice. However, physicians might reject such guidelines as "cookbook medicine" or bureaucratic infringements on physicians' professional judgment.

Direct Limitations on Services

Most insurance plans have formularies that exclude certain expensive drugs and provide financial incentives to patients to use generic drugs and preferred drugs for which plans have negotiated favorable prices.

DESELECTION

Some physicians fear that their contract with an insurance care plan will not be renewed if they are identified as high utilizers of resources or appeal many utilization review decisions (51,52). Such concerns might lead physicians to provide fewer services, independently of any direct financial incentives to do so.

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CHAPTER 33

Gifts from Drug Companies

Gifts from drug companies to physicians are ubiquitous. One study found that 97% of residents were carrying at least one item, such as reference books (90%), pens (79%), and information cards (70%), that had pharmaceutical insignia (1). Although gifts and subsidies from drug companies might foster medical education and provide welcome perks to physicians and students, some gifts might impair the physician's judgment or create the impression of a conflict of interest. This chapter presents arguments for and against accepting gifts from drug companies or manufacturers of medical products and suggests guidelines for such gifts.

TYPES OF GIFTS

In 2003 pharmaceutical manufacturers spent over $13 billion—almost 12% of sales—in advertising and promotions to physicians (2). Gifts and subsidies from drug companies to physicians range from token to lavish.

Small gifts that bear the company or product name include pens and message pads, as well as more expensive items such as umbrellas, flashlights, and clocks. Drug companies might also distribute medical books and equipment, such as reflex hammers.

MEALS AND HOSPITALITY

Drug companies frequently provide lunch or refreshments at hospital conferences or continuing medical education (CME) courses. Conference organizers often solicit these subsidies to increase attendance. Companies also host dinners coupled with a talk for physicians.

CONTINUING MEDICAL EDUCATION AND CONFERENCES

Drug companies might support hospital conferences by paying honoraria and travel expenses for speakers. Over half the support for continuing medical education programs is from commercial entities. In an era of financial constraints, such subsidies might enable hospitals or medical schools to invite nationally prominent experts. Drug companies might also subsidize continuing education courses and professional society meetings in exchange for setting up booths to display their products.

REASONS FOR DRUG COMPANIES TO OFFER GIFTS

One commentator observed, "No drug company gives away its shareholders' money in an act of disinterested generosity (3)." There is substantial evidence that drug companies strengthen recognition

of their products through gifts to physicians (4). One study found that doctors who attended a drug company–sponsored CME or who accepted funds for travel or lodging for educational symposia were more likely to prescribe the sponsor's medications. This occurred even if physicians forgot the sponsors' names or believed that they could not be influenced. Doctors who met with pharmaceutical representatives or accepted industry-paid meals were more likely to request formulary additions or to prescribe in nonrational ways. Physicians who received gifts from pharmaceutical manufacturers, even practice-related gifts, were more likely to believe that gifts did not affect prescribing behavior.

REASONS FOR ACCEPTING DRUG-COMPANY GIFTS

Gifts from drug companies might subsidize continuing education courses and thereby enhance medical education and professional society meetings. Even providing lunches for hospital conferences might improve educational programs by increasing attendance. Thus, some argue that all drug-company gifts and subsidies overall have more benefit than harm. If physicians refused all gifts and subsidies from drug companies, patients would pay the same amount for drugs but their physicians would receive less education.

OBJECTIONS TO ACCEPTING DRUG-COMPANY GIFTS

Table 33-1 summarizes objections to accepting gifts from drug companies.

GIFTS CREATE THE EXPECTATION OF RECIPROCITY

Gifts create relationships and obligations in the recipient, such as grateful conduct, good will, and reciprocation (5,6). The problem is not that physicians would immediately change prescribing practices after receiving a free lunch. Rather, as one writer has warned, "The sell is much more subtle. All the advertiser may expect is that, other things being equal, if you subsequently have to make a decision it is more likely to be in the favor of the advertiser (7)."

GIFTS IMPAIR OBJECTIVITY

Objectivity of presentations at conferences and continuing education courses might be compromised if the drug company selects speakers and topics, prepares slides for presentations, writes or edits talks, or trains the presenters (8). A speaker might selectively present or emphasize data favorable to one drug or class of drugs rather than draw from the overall body of available data (9). Research sponsored by pharmaceutical companies is more likely to report results that favor the sponsor's drug than research sponsored by nonprofit organizations (10–12). Studies find bias in the design and publication of results in some industry-sponsored clinical trials (13,14).

When academic institutions sponsor CME programs, physicians expect the institution to select the speakers and topics independently without drug company interference. Because the bias introduced into programs supported by pharmaceutical companies is "almost never obvious (8)," it might have a greater impact than clear-cut advertising by drug companies.

TABLE 33-1

Objections to Accepting Gifts from Drug Companies

Gifts create the expectation of reciprocity.
Gifts impair objectivity.
Gifts increase the cost of health care.
Gifts demean the profession.
Gifts give the appearance of conflict of interest.

GIFTS INCREASE THE COST OF HEALTH CARE

Ultimately patients and their insurers pay for drug-company gifts to physicians. Given the rising cost of drugs, it might be unseemly for physicians to receive even small gifts from drug companies. One physician criticized, "Am I supposed to believe that the members of a clinical department are so impoverished that they cannot buy their own pens or pizza and beer?" (7). Even low-cost gifts, such as pens and notepads, might undermine evidence-based prescribing by reminding physicians of certain drugs, regardless of their actual effectiveness.

GIFTS DEMEAN THE PROFESSION

Dependence on drug-company subsidies to support CME programs demeans physicians (7). If the public realized that physicians attend conferences only if lunch is provided or the registration fee is subsidized, they might infer that physicians place little value on keeping up to date with medical research.

GIFTS GIVE THE APPEARANCE OF CONFLICT OF INTEREST

Even if gifts from pharmaceutical companies do not actually influence a physician's therapeutic decisions, the appearance of bias and conflict of interest might be deleterious. After all, physicians are not choosing medications for their own use and paying the bills themselves; they are prescribing for their patients. According to one survey, patients are more likely than physicians to believe that gifts are not appropriate and that gifts influence physician behavior (15). About 30% of patients believe that even small gifts such as a mug, pen, or lunch would influence physician behavior, compared to about 10% of physicians (15).

Outside of medicine, society has enacted strict rules regarding conflicts of interest that might undermine trust in public officials. Judges are expected to refuse gifts from persons or companies who have a financial stake in their professional decisions. Government officials may not accept gifts of more than nominal value from persons or organizations who would be affected by or gain financially from their decisions. By analogy, it might be inappropriate for physicians to accept drug-company gifts that create even the appearance of a conflict of interest.

RECOMMENDATIONS

FORBID CERTAIN PRACTICES

Certain types of gifts and support from drug companies are so likely to raise questions about bias and impropriety that they should be banned (8,16). For example, the American College of Physicians, the American Medical Association, the Accreditation Council for Continuing Medical Education, and the Pharmaceutical Manufacturers Association agree that it is unethical for physicians to accept direct payments to attend activites that have no educational value (17). Course directors should retain complete control of the scientific program and choice of speakers when drug companies support CME. In addition, the company should not select the physicians who attend the educational program or pay for their expenses or time. In accredited CME, speakers' conflicts of interest must be resolved. Any honoraria or consulting fee from commercial entities is considered a conflict of interest (18). Recently the pharmaceutical industry declared that occasional meals provided in conjunction with informational presentations must be modest. Drug company representatives may not provide items for the personal benefit of healthcare professionals, such as tickets to a sporting or recreational event. Drug company representatives may not provide items, such as tickets to a sporting or recreational event for healthcare professionals' benefit.

ALLOW CERTAIN OTHER PRACTICES

Some types of gifts or support are widely considered acceptable. At professional society meetings, drug companies often underwrite the printing of abstract books. In turn, they set up displays in an exhibition hall. Many physicians accept pens or note pads that bear the names of drug companies

or their products. However, even these small items might impair objectivity and give the appearance of conflicts of interest.

DISCLOSE GIFTS TO THE PUBLIC

It might be difficult to distinguish between what is acceptable and what is not. A helpful rule of thumb is, "What would your patients or the public think if they knew you had accepted these gifts?" (17). In borderline cases it would be judicious to err on the side of declining gifts.

In summary, gifts from drug companies might raise at least the appearance of conflicts of interest, increase the cost of health care, and impair objectivity. Physicians need to remember that ultimately their primary concern should be their patients' best interests, not their own personal convenience or well-being.

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CHAPTER 34

Disclosing Errors

An estimated 40,000 Americans die every year because of medical errors (1). In one survey 42% of the public and 35% of physicians reported that an error had occurred in their care or a family member's care (2). Disclosure of mistakes to patients and colleagues is difficult for physicians, who might fear recriminations from patients, setbacks to their professional reputation or livelihood, and lawsuits. One study found that house officers who made serious errors reported them to attending physicians in only 54% of cases and to patients or families in only 24% of cases (3). In another survey one third of physicians said they would not tell the family about an error that was fatal to the patient (4). The following case illustrates dilemmas posed by physicians' errors.

CASE 34.1 Overdose of insulin.

A 54-year-old man with diabetes is hospitalized for congestive heart failure. The resident prescribes 100 units of insulin rather than the patient's usual dose of 10 units, and the patient receives the higher dose. He develops hypoglycemia, seizures, and coma. Upon recovery, both the patient and his family ask physicians why the seizures occurred. The health care team wonders how to respond.

The patient and family naturally want to know why his condition changed so dramatically. The team is reluctant to tell them that an error occurred, fearing that they would get angry and perhaps take legal action.

Traditionally, such errors have been viewed as deficits in knowledge, effort, or conscientiousness, and the physician who wrote the wrong dosage would be blamed. However, a different view of error has been accepted, one that makes blaming the physician problematic (5–7). First, errors like the one in Case 34.1 usually are due to a momentary loss of concentration or attention, which are beyond the doctor's voluntary control. Such lapses are unavoidable because human cognition and attention are limited and fallible. A "slip of the pen" could happen to the most expert and careful physician. Second, there are multiple system causes for the error. The pharmacist who dispensed the medication and the nurse who administered it failed to detect the incorrect dosage. The resident or attending physician might have provided inadequate supervision. More training for physicians, nurses, and pharmacists is unlikely to reduce these errors. Instead, the health care delivery system needs to be redesigned (8). For example, computerized ordering of medications would reliably detect such errors in dosage. Furthermore, communication and working relationships among physicians, pharmacists, and nurses might need to be changed.

This chapter discusses the reasons for and against disclosing errors and suggests how physicians can respond to them. *Error* refers to a failure of a plan to be completed as intended or the use of a wrong plan to achieve an aim (1). Errors can be either acts or omissions. Errors might—or might not—result in harm to patients; when no harm is done, the incident is called a *near miss* or a *close call*. Errors can or cannot be avoidable. Adverse events are defined as undesired patient

outcomes that result from medical care rather than from the underlying disease; they include situations in which the treatment plan was appropriate and carried out correctly, such as side effects of drugs.

REASONS NOT TO DISCLOSE ERRORS TO PATIENTS OR SURROGATES

Physicians commonly offer several reasons against disclosing serious errors to patients or surrogates.

THE PHYSICIAN IS NOT REALLY RESPONSIBLE FOR THE ERROR

Physicians understandably do not want to take the blame for errors if they are not morally responsible. If systems flaws and limits in human cognition cause errors, they are beyond people's control. Individual physicians should not be held morally responsible for actions and events beyond their control (5). Thus, the traditional response of blaming the individual for errors might not enhance patient safety, except in the case of negligent or intentional violations of a clear standard of care or performance (5). Similarly, remedial education programs can be effective only in situations in which a deficiency in knowledge or skill causes the error. Instead, with most errors, patient safety can be enhanced only by systems-level responses that provide additional defenses against the adverse consequences of errors. Examples of such defenses that might be useful in Case 34.2 are checklists, bar coding, and computerized ordering of medications. This systems approach to errors has proved effective in the field of anesthesia and in other complex fields such as commercial aviation. Determining the cause of a serious error is essential to improving quality of care and preventing recurrences of the error, but uncertainty over cause and responsibility should not deter physicians from informing patients or surrogates about the error.

DISCLOSURE WOULD HARM THE PATIENT OR SURROGATE

Physicians might believe that if errors are disclosed, patients or surrogates might worry unnecessarily about other aspects of care. Such worry might cause stress or deter patients from seeking necessary care or accepting beneficial interventions in the future.

DISCLOSURE WOULD HARM HEALTH CARE PROFESSIONALS

Physicians might fear that patients or families might respond to disclosure of errors by becoming angry, filing a lawsuit, or leaving the physician's practice. In surveys most respondents said they would change physicians if their physician committed a life-threatening error (9,10). The reluctance of physicians to acknowledge errors, however, creates a vicious circle because patients become more upset if they believe physicians are not forthright about an error.

Health care workers might be concerned that their reputations or careers will be damaged if they disclose a serious error to a supervising physician. Colleagues and supervisors who are told of an error might be punitive rather than supportive (3).

REASONS TO DISCLOSE ERRORS TO PATIENTS OR SURROGATES

There are several strong reasons to disclose errors to patients or their surrogates (Table 34-1).

DISCLOSURE RESPECTS THE PATIENT

Almost all patients report that they would want even minor errors disclosed to them (9,10). Patients want to know what happened, why it happened, how adverse consequences will be mitigated, and how recurrences will be prevented (11). In addition, patients seek an apology (11). Disclosure would reassure them that they are receiving complete information about their care and would enhance their trust in physicians. Unless the patient in Case 34.1 is told about the insulin overdose, he cannot understand this episode. He might well fear that seizures and coma will recur or that he

TABLE 34-1

Reasons to Disclose Mistakes to Patients or Surrogates

Disclosure respects the patient.
Disclosure benefits the patient.
Disclosure benefits the physician.
Disclosure maintains public trust.

has a grave problem, such as a brain tumor. Fearing a recurrence, he might change jobs or cut back on activities such as driving or travel. Under the doctrine of informed consent, physicians have an affirmative duty to provide the patient or surrogate with pertinent information about the patient's condition and the options for care. This duty to disclose goes beyond merely responding honestly to questions. In thinking about disclosure, physicians might imagine that the patient is a close relative. How would they feel if a dramatic change occurred in their relative's condition and the health care team was not forthright about what happened?

DISCLOSURE BENEFITS THE PATIENT

Disclosure enables patients or surrogates to take steps to mitigate the harms that the error caused. Patients might need additional tests, treatment, close monitoring, or additional follow-up care. Patients or families are more likely to cooperate with such measures if they understand the reasons for them.

Disclosure might also allow patients to be compensated for harms resulting from errors. In Case 34.1 the patient required intensive care, a prolonged hospitalization, and a computed tomography (CT) scan following the error. It seems unfair and callous to ask the patient or an insurer to pay for this additional care. Moreover, most patients want charges for such care to be waived (9). Furthermore, it is seems reasonable to compensate patients for lost income or serious disability resulting directly from errors (12). Patients cannot negotiate such compensation unless they or their surrogates are aware that an error occurred.

DISCLOSURE BENEFITS THE PHYSICIAN

When a serious error has been made, it seems callous and deceptive not to admit it and to avoid taking responsibility for it. When a person harms another, apologizing is the expected social response and a prerequisite to making amends and being forgiven (13,14).

Disclosure might also mitigate adverse impacts on the physician's livelihood. One study found that patients are less likely to change doctors if they are told of errors and the physician accepts responsibility (9). However, in most scenarios, disclosure and apology did not reduce the respondent's likelihood of seeking legal advice.

Nondisclosure might worsen the situation for the physician. The patient or family will likely learn the cause of a dramatic complication, such as the seizures in Case 34.1. They will probably feel outraged and betrayed if they were not informed promptly. In one survey patients said that they would be more likely to sue if the physician had not informed them of an error and they found out in some other way than if the physician voluntarily admitted the error immediately after committing it (10). Legal liability might also be greater if the physician conceals negligent actions and the patient is harmed by reliance on such misrepresentation (15).

DISCLOSURE MAINTAINS PUBLIC TRUST

Nondisclosure might harm the profession as a whole, not just the individual physician. If the public perceives a pattern of nondisclosure, patients might believe that doctors are more concerned with protecting themselves than with doing what is best for patients. Such mistrust might affect other aspects of care.

WHAT SHOULD PHYSICIANS SAY TO PATIENTS?

The Joint Commission for the Accreditation of Health Care Organizations requires hospitals to tell patients when unanticipated outcomes of care occur (16). However, many hospitals report that they would not disclose preventable harms, primarily because of concerns about malpractice (17).

In Case 34.1 the physician clearly made an error, the patient suffered serious harm, and the error caused a poor outcome. Under these circumstances the physician's responsibility to the patient should prevail over any self-interest in concealing the error. The physician should take the initiative in disclosing relevant information. First, physicians should explicitly acknowledge that an error occurred and offer an apology (12). Second, the physician needs to explain the error and its consequences. Third, the physician should explain what can and will be done to mitigate the resulting harms to the patient and to prevent the error from recurring.

Some physicians might make only limited disclosure of errors—for example, telling the patient and family in Case 34.1 only that the seizures were caused by low blood sugar, without saying that an error occurred. Other physicians might say they regret what happened but take responsibility for the error. However, a partial apology might be worse than none; patients might view them as evasive and mean-spirited. In addition, the patient and family are likely to probe for details—for example, to ask what caused his glucose to be low. The most appropriate ethical response to concerns about a lawsuit in Case 34.1 would be for the risk manager to offer a fair out-of-court settlement.

SITUATIONS IN WHICH DISCLOSURE IS CONTROVERSIAL

In many cases it might not be clear that the physician should disclose an error to patients or take responsibility for it.

THE ERROR CAUSED NO HARM

Sometimes physicians make definite errors but the patient suffers no harm. These errors have been called "near misses."

CASE 34.2 Incorrect prescription.

A physician prescribed a sulfonamide antibiotic to a patient with a history of allergy to those medications. A nurse discovered the error, and the prescription was changed after two doses. No adverse effects occurred.

Such near misses need to be reported to quality improvement programs in order to identify system problems that might lead to similar errors that do harm patients. However, should such near misses be disclosed to the patient? In Case 34.2 some physicians might argue that if the prognosis or future care of the patient is not altered, there is no point in telling the patient of the error. Such physicians might hesitate to burden patients with all the uncertainties and adjustments made in the course of care. In addition, patients might be harmed if they lost confidence in physicians and hospitals.

Even in this case, however, there are strong reasons to disclose the error to patients. Disclosure is likely to strengthen the doctor–patient relationship because patients respect physicians for being honest. Disclosure might also promote patient well-being; because of this error the diagnosis of drug allergy might be reconsidered. Furthermore, patients themselves might call attention to errors—for example, after noticing that the medication has been changed. If this occurs, physicians might find it difficult to explain the situation if the physician did not tell the patient of the error immediately. Finally, there is little risk to physicians in disclosing "near misses" because patients who suffer no harm are unlikely to get angry with the physician and cannot sue if no harm occurred.

OUTCOME WOULD HAVE BEEN POOR EVEN WITHOUT THE ERROR

In other cases the physician makes an error and the patient suffers a poor outcome but the poor outcome would have occurred even if there had been no error. The adverse outcome, for example, might be due to the underlying disease.

CASE 34.3 Failure to administer appropriate treatment.

A 52-year-old man developed vomiting and ataxia, followed by stupor and coma. He was taken to the emergency department, where he had a blood pressure of 200/105, which was not treated while a CT scan was obtained. He was found to have a cerebellar hemorrhage and died in the emergency department.

In this case standard care would be to lower blood pressure before obtaining the CT scan. However, once comatose, he would almost certainly have died even if his blood pressure had been lowered.

In such situations, when telling the family about the patient's death, the physicians should not say that an error was a contributing factor. Physicians must recognize, however, that determining whether an error caused an adverse outcome is very difficult (18) and that their belief that the error caused no harm to the patient might be biased or self-serving. Consultation with an experienced colleague might help physicians evaluate their judgment and actions accurately.

Even if an error is not mentioned, family members might ask physicians whether everything was done to prevent an adverse outcome. This question deserves both a literal and deeper response. On the literal level, it would be deceptive to say that everything was done when the physician knows that this was not the case. On another level, the survivors might be asking whether *they* should have acted differently or whether the patient suffered needlessly. The physician needs to acknowledge and respond to these concerns. For instance, the physician might say, "It's natural when someone dies suddenly to ask if anything more could have been done. In hindsight, we may all wish we had acted differently. When a patient dies in the emergency department, we review the case to see if there are any things we can improve for the next case. However, once patients with this kind of bleeding into the brain lose consciousness, the bleeding is so severe that they don't recover. . . . One thing that is clear is he didn't suffer."

ADVERSE OUTCOME COULD NOT HAVE BEEN AVOIDED

Some adverse events related to a procedure are due to a mishap during the procedure, such as poor technique or a slip of the instrument. System factors, such as inadequate training or supervision, might be contributing factors. In other cases, however, the unintended outcome could not have been avoided.

CASE 34.4 Foreseeable complication of an invasive procedure.

A 43-year-old man with interstitial lung disease undergoes a bronchoscopy and transbronchial biopsy. The procedure is performed following accepted procedures. He suffers a pneumothorax that requires insertion of a chest tube for 2 days. The patient was informed of this risk prior to the procedure.

In this case the patient suffered a known complication of an invasive procedure that was appropriate and skillfully performed. The physician needs to review the case to be certain that the standard of care was followed. The patient agreed to the procedure and accepted the risks. Although the physician must explain the unintended adverse outcome and should express regret over it, the doctor is not to blame for this complication.

DISCLOSING ERRORS BY TRAINEES TO AN ATTENDING PHYSICIAN

In teaching hospitals serious errors by trainees might not be reported to attending physicians (3).

DISCLOSURE OF SERIOUS ERRORS BY TRAINEES TO SUPERVISING PHYSICIANS

Students, house officers, and fellows might be reluctant to tell supervisors about errors because they might fear that grades, recommendations, or future positions might be jeopardized. Supervisors might also be judgmental rather than supportive when told of errors.

Attending physicians, however, are ethically and legally responsible for patient care. They cannot perform this role adequately if significant information about the patient is withheld. Importantly, attending physicians might learn of such errors even if trainees do not disclose them. Most

supervising physicians believe that failure to disclose errors is worse than making them in the first place (19). Although trainees are expected to make some errors, covering them up raises doubts about reliability, trustworthiness, and character.

RESPONSES TO ERRORS BY TRAINEES

Once a trainee has disclosed an error, the supervising physicians need to respond on several levels.

Elicit and Acknowledge the Trainee's Emotional Distress

Appropriate emotional support needs to be provided. The supervisor can put the trainee's feelings in context: Although it causes distress to admit an error, it is a sign of responsibility and caring. Moreover, it is essential to do so if the trainee is to learn from the error (3). Understanding this link between emotional distress and learning might offer the resident some solace.

Review the Medical Issues and Decisions

The supervisor can help the trainee learn from the error and make constructive changes in practice to prevent similar errors in the future. Such constructive changes might include seeking more advice in difficult cases, reading more about the medical problem, and confirming key clinical data personally rather than relying on someone else's report (3). Discussing errors explicitly can also help other trainees avoid similar errors (20).

Discuss How to Disclose the Error to the Patient or Surrogate

If disclosure is appropriate, the attending physician should inform the patient together with the trainee. Such joint discussions would provide trainees with emotional support and role modeling.

ERRORS BY OTHER HEALTH CARE WORKERS

A physician might become aware of a definite error by another health care worker that seriously harmed a patient. For example, in Case 34.1 a coworker on the primary team, another clinical service, or a different hospital might have made the overdose of insulin. Even if the current physician did not make the error, the patient still needs to understand what happened and perhaps take action to mitigate the harms caused by the error. Thus, the current physician might question whether he or she should disclose the error to the patient.

ETHICAL ISSUES REGARDING ERRORS BY OTHER HEALTH CARE WORKERS

From the patient's perspective, the reasons for disclosing errors to patients hold for errors by other health care workers as well as one's own errors. However, it is often more difficult for physicians to deal with errors by other health care workers. The facts of the case might be unclear. Even if physicians review the medical record, they might not know what actually happened, particularly at another hospital. In addition, disclosure might conflict with the current physician's self-interest. The other physician or institution might become irate or stop referring patients. Physicians in training who notice a serious error by a senior physician might fear retaliation (*see* Chapter 36). In addition, the patient or family might vent their anger on the current physician, who bears no responsibility for the error.

RESPONSES TO ERRORS BY OTHER HEALTH CARE WORKERS

Faced with a clear and serious error by another health care worker, the current physician might take several approaches.

Wait for the Patient to Ask

Waiting for the patient to ask is ethically problematic because physicians have an affirmative obligation not only to answer patients' questions honestly but also to disclose relevant information to patients.

Ask the Other Physician to Disclose

Although asking the other physician to disclose the error might be easiest for the current physician, it might be problematic for the patient or family. The previous physician might choose not to tell the patient or might provide misleading information about the error.

Arrange a Joint Conference

If the patient is still receiving care at the institution in which the error occurred, a conference might be held with the current physician, the previous physician, and the patient or family. This approach allows the other physician to take the lead in revealing the error while ensuring that the discussion is appropriate.

Tell the Patient

Although telling the patient leads to appropriate disclosure, it might undermine the relationships between the patient and the previous physician and between the two physicians. It is possible that the other doctor wanted to talk to the patient directly and would have carried out the discussion appropriately. If this approach is taken, it would be preferable to give the other physician the opportunity to talk to the patient first.

In summary, the decision to acknowledge an error should be based on ethical guidelines, not on expedience. Disclosure of errors is difficult, but failure to disclose errors that cause serious harm undermines physicians' credibility and compromises their integrity. Anticipating potential adverse consequences of disclosure allows physicians to cope with them. Ultimately the quality of medical care is enhanced if physicians are willing to admit their errors and learn from them.

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CHAPTER 35

Impaired Colleagues

Physicians who are impaired or incompetent might harm patients. Society relies on the medical profession to regulate itself (1), yet colleagues of impaired physicians are often reluctant to intervene, even in egregious cases. The following case illustrates common dilemmas regarding impaired colleagues.

CASE 35.1 Drinking alcohol while on call.

Dr. New, a young internist who has recently joined a group practice, is at a party. She overhears a senior colleague, Dr. Elder, answer a page. Dr. Elder has been drinking and has slurred speech. Over the phone he prescribes 1.25 mg of digoxin, an unusually large dose. From what she hears of the conversation, Dr. New suspects that she has previously covered for this patient, an elderly man with mild renal insufficiency, a recent hip fracture repair, and postoperative pneumonia.

Dr. New is in a quandary. Although she suspects that a patient is at risk of a drug overdose, she cannot be sure. Should she intervene to protect the patient from this suspected mistake? If so, should she confront Dr. Elder or talk to the house officer or nursing supervisor covering the service? Even if she protects this patient, what about other patients Dr. Elder might harm? Dr. New wants to prevent harm to patients, but she is reluctant to jeopardize the career of a colleague or her own future.

This chapter discusses intervening with impaired colleagues, reasons to take action, and practical suggestions. Chapter 34, which discusses errors, contains related materials. Errors by impaired or incompetent colleagues are more serious than other errors because they are more likely to be repeated. Although many errors are due to system problems, those discussed in this chapter are due to shortcomings of an individual physician.

CAUSES OF IMPAIRMENT AND INCOMPETENCE

Common causes of impairment are alcoholism, substance abuse, and psychiatric and medical illness, such as depression and Alzheimer's disease (2). Many impaired physicians can be treated effectively in programs that stress confidential rehabilitation rather than punishment (3). Physicians might also be incompetent because of inadequate knowledge and skills or careless behavior—for example, failing to round on patients.

REASONS FOR INTERVENING WITH IMPAIRED COLLEAGUES

Physicians have an ethical obligation to be competent, based on the ethical guidelines of refraining from causing harm and acting in their patients' best interests. There are also compelling ethical reasons for physicians to intervene with seriously impaired colleagues, even though the patients who might be harmed are not their own (Table 35-1).

TABLE 35-1

Reasons for Intervening with Impaired Colleagues

To prevent harm to patients.
To carry out professional self-regulation.
To help the impaired colleague.

PREVENT HARM TO PATIENTS

People have a duty to prevent serious harm to others when it can be done at minimal risk or inconvenience to themselves (4). Modern professional codes of ethics also require physicians to protect patients from impaired colleagues. The American College of Physicians Ethics Manual states, "It is the responsibility of every physician to protect the public from an impaired physician.... All steps must be taken to assure that no patient is harmed because of actions or decisions made by an impaired physician (5)." An impaired physician's colleagues might be in a unique position to prevent harm to patients because they have not only the expertise to evaluate the quality of care rendered by colleagues but also the opportunity to do so.

In other occupations workers whose impairment might endanger the public are aggressively identified. For example, airline pilots and train engineers are required to submit to drug testing before hiring, after accidents, and on a random basis (6). A commercial pilot who is suspected of drinking while on duty may be removed from the cockpit. Critics charge that the treatment of impaired physicians, in comparison, is too lax. It seems inconsistent to forbid pilots to drink while on duty but to allow physicians to drink while on call.

CARRY OUT PROFESSIONAL SELF-REGULATION

Society grants the medical profession considerable autonomy to regulate itself through selecting applicants for medical school and residency, defining standards of practice, certifying physicians, and disciplining members. The rationale for such professional autonomy is that laypeople do not have the expertise to determine whether physicians are impaired or incompetent. Society expects the profession to screen out practitioners who might endanger patients. If people believe that physicians are covering up for impaired or incompetent colleagues, they will lose trust in the medical profession and society might regulate physicians directly.

HELP THE IMPAIRED COLLEAGUE

Impaired physicians might harm themselves and their families as well as their patients through automobile accidents, violent episodes, or lapses in judgment. Furthermore, impaired physicians might destroy their livelihood and their families' economic security. Intervening with impaired colleagues might avert such destructive outcomes.

CONCERNS ABOUT INTERVENING WITH IMPAIRED COLLEAGUES

State licensing boards provide strong evidence that physicians are reluctant to intervene with impaired colleagues. Compared with the estimated prevalence of impairment, state boards receive few reports about impaired physicians (7). There might be several reasons for such reluctance.

UNCERTAINTY WHETHER PATIENTS ARE AT SERIOUS RISK

Physicians might be uncertain whether colleagues suspected of impairment are actually placing patients at risk, as in Case 35.1. Dr. New does not know the complete story. Perhaps the patient needed a high dose because he had uncontrolled atrial fibrillation or intestinal malabsorption.

RELUCTANCE TO CRITICIZE COLLEAGUES

Physicians rely on their colleagues' skills, knowledge, and judgment, and it would be difficult to practice medicine without such reliance. Thus, doctors might hesitate to admit that a colleague is impaired because it calls such trust into question. Physicians might also hesitate to probe matters that are often considered private, such as alcohol consumption. Dr. New, for example, might be reluctant to act on the basis of a personal telephone conversation that she accidentally overheard.

Furthermore, doctors are understandably reluctant to undermine a colleague's reputation and livelihood. On a subconscious level physicians might identify with impaired colleagues. If they question a colleague's competence, might other physicians in turn criticize them harshly after a minor error?

RETALIATION AGAINST WHISTLEBLOWERS

Whistleblowers often face personal retaliation despite their good intentions. If Dr. New confronts Dr. Elder, he might get angry or tell her to mind her own business. If she tells other people, colleagues might label her a snitch or a tattletale. Dr. Elder might accuse her of trying to ruin his reputation or trying to build up her own practice. He might even retaliate by criticizing her work and discouraging other physicians from referring patients to her. Dr. Elder could potentially go so far as to sue her for defamation of character or lost income. Even the threat of a lawsuit, its concomitant cost, and adverse publicity might deter Dr. New from pursuing the matter. Dr. New's natural concern about her own career might conflict with her desire to prevent harm to vulnerable patients.

LEGAL ISSUES REGARDING IMPAIRED COLLEAGUES

Many states have adopted laws concerning reporting of impaired or incompetent colleagues (1,8).

REPORTING LAWS

The specific provisions of reporting laws vary from state to state. In Massachusetts physicians must report to the state licensing board colleagues whom they suspect are practicing medicine while impaired. Other states permit such reporting but do not require it. Most states grant legal immunity from civil suits to physicians who report colleagues in good faith.

DIVERSION PROGRAMS

Most states have set up voluntary physician health programs, which are often run by the state medical society rather than the medical licensing bureau, to treat and rehabilitate impaired physicians (3,9). The goal is to allow rehabilitated physicians to continue to practice or to return to work. Physicians entering such programs may be granted confidentiality and immunity from disciplinary actions. That is, physicians are diverted from disciplinary procedures. Several states have reported success in rehabilitating impaired physicians in such programs (2).

THE HEALTH CARE QUALITY IMPROVEMENT ACT

In 1986, Congress passed legislation regarding reporting of incompetent physicians (10). This law requires hospitals and state licensing agencies to report to a federal agency most disciplinary actions related to professional incompetence or misconduct. In addition, insurance companies must report malpractice payments above $10,000. These reports are entered in the National Practitioner Data Bank. To prevent incompetent or impaired physicians from simply resigning from one hospital staff, relocating, and continuing to practice elsewhere, hospitals are required to obtain information from the National Practitioner Data Bank when physicians apply for hospital privileges and periodically thereafter.

The law also confers legal immunity on persons and hospitals who report impaired colleagues in good faith. Specifically, immunity is given to persons who provide "information to a professional review body regarding the competence or professional conduct of a physician (10)." In addition,

peer review bodies and persons who work with or assist them are granted legal immunity. Note, however, that in Case 35.1 these provisions would not protect Dr. New if she were to attempt to deal with Dr. Elder outside the formal peer review process.

DEALING WITH IMPAIRED COLLEAGUES

Physicians can deal with impaired colleagues in several ways (Table 35-2).

PROTECT PATIENTS FROM IMMEDIATE HARM

If Dr. New believes that Dr. Elder's order might seriously harm the patient, she should take immediate action. She might consider saying, "I'm sorry to intrude, but I thought I heard you say 1.25 mg of digoxin. I'm afraid the nurses might have heard the wrong dose as well." If the matter is not resolved satisfactorily, Dr. New could call the hospital and ask the nursing supervisor at the hospital to look into the case. Dr. New should also intervene if Dr. Elder is apparently drunk on call even if she had no direct evidence that he had made a questionable medical decision. If Dr. Elder does not agree to have a colleague take calls for him, it would be prudent to notify another senior physician or the chief of the department and arrange for someone else to take calls, at least until Dr. Elder regains sobriety.

DETERMINE WHETHER FURTHER ACTION IS NEEDED

After preventing immediate harm to patients, Dr. New needs to assess whether additional action is needed. Gathering more information about the impaired colleague can usually be done discreetly.

Because whistle-blowing is emotionally difficult and personally risky, physicians might take smaller steps to prevent harm to patients. Many physicians would not refer patients to such a colleague but would otherwise let the matter drop. Other physicians cover up for impaired colleagues rather than confront them. For example, a physician might review a colleague's work and correct that doctor's errors. Although well-intentioned, such actions are ineffective in the long run. To try to monitor all the clinical activities of an impaired or incompetent colleague is impractical and also counterproductive because it simply allows the physician to deny the impairment.

TALK WITH THE COLLEAGUE DIRECTLY

A physician will often want to talk with an impaired colleague directly, particularly if the colleague is a friend. Although such conversations are uncomfortable, they can be effective. The matter can be resolved if the impaired colleague agrees to seek help—for example, by enrolling in a rehabilitation program. Alternatively, physicians impaired by physical illness might decide to retire or to restrict the scope of their practice.

REPORT THE PROBLEM TO RESPONSIBLE OFFICIALS

Dr. New does not need to solve the problem of the impaired colleague by herself. She needs only to decide whether there is sufficient suspicion of impairment to warrant further investigation. In Case 35.1, Dr. New directly observed a situation of potential harm to a patient. She can discharge

TABLE 35-2

Dealing with Impaired Colleagues

Protect patients from immediate harm.
Determine whether further action is needed.
Talk with the colleague directly.
Report the problem to responsible officials.

her ethical obligations by reporting impaired colleagues to officials who can investigate and take appropriate action. Such officials are the chief of service, the chief of staff of the hospital, or, if a trainee is involved, the director of a training program or student clerkships. These persons are responsible for ensuring the quality of patient care and the competence of medical staff. Alternatively, Dr. New might refer her colleague to the hospital's employee assistance programs or to the state medical society's physician health program (3). In cases of egregious impairment or incompetence, notifying the state licensing board directly might also be advisable. The case's circumstances often determine how physicians prefer to respond to an impaired or incompetent colleague. In one survey most house officers said they were willing to confront a fellow house officer who was impaired by alcohol but preferred to tell the chief resident or the chief of medicine about an attending physician who was similarly impaired. However, house officers were less comfortable confronting a fellow house officer who was incompetent rather than impaired and preferred to refer such matters to a more senior physician (11).

In summary, there are understandable practical reasons for physicians' hesitation to intervene with impaired colleagues. However, there are cogent ethical reasons for physicians to take action to prevent impaired colleagues from harming patients. Pragmatically, there are ways to do so that are safe for whistle-blowers.

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CHAPTER 36

Ethical Dilemmas Students and House Staff Face

Every clinician in training has entered a patient's room to perform a procedure knowing that someone else could do it more skillfully.

CASE 36.1 Performing an invasive procedure.

Obviously tired after a 9-hour wait in the emergency room, a woman with an asthma exacerbation is finally admitted to the floor. "Oh no, not another needlestick!" she groans, as a medical student approaches to draw arterial blood gases. The medical student gulps silently, aware that his previous attempts at drawing blood gases have been unsuccessful or required multiple punctures.

Trainees' self-interest in learning might conflict with their patients' best interests. Learning clinical skills and taking responsibility might present inconvenience, discomfort, or even risk to patients. Ethical conflicts also arise when trainees observe unethical or substandard care by other physicians. Both trainees and patients benefit when these issues are addressed openly. Ideally, the patient's welfare should be paramount. However, trainees must also be realistic about the power that more senior physicians have over them.

LEARNING ON PATIENTS

In their training medical students might worry that they are taking unfair advantage of patients but hesitate to voice their concerns to their supervisors (1,2). They fear that their reputation or career might suffer if others believe they are reluctant to accept responsibility or are not competent.

INTRODUCING TRAINEES TO PATIENTS

CASE 36.2 Introducing students as physicians.

The attending physician introduces a medical student beginning a third-year clerkship to the patient as "Doctor." When the student raises concerns about this, the attending physician insists that students have to get over their "hang-ups" about taking responsibility. According to the attending physician, patients who seek care at a teaching hospital know that students will be taking care of them. If they did not agree, they would not come to a teaching hospital.

Introducing students as physicians is common (3). In fact, 27% of medical schools fail to identify students as medical students, student doctors, or student physicians on their name tags (4). Several reasons are offered for not introducing trainees as such (5). Patients might not trust trainees or might worry needlessly about provision of care. As in Case 36.2, some physicians believe that patients in a teaching hospital have given "implied consent" to trainees to care for them.

There are compelling reasons to introduce students truthfully. Patient trust cannot be built on misrepresentation. Patients who are misled about a health care provider's role might feel betrayed if they discover the trainee's status. Informed consent requires physicians to disclose pertinent information to patients (*see* Chapter 3). The identity of trainees who will provide care can be highly relevant to a patient's decisions. State laws and accreditation requirements can also require trainees to disclose their educational status to patients (5). The argument that patients who seek care at teaching hospitals have given implied consent to be "teaching material" is untenable. The concept of "implied consent" applies only to emergency situations in which delaying treatment would seriously harm a patient who is unable to give consent.

Protecting patients from unnecessary worry is also an unconvincing reason to withhold information. Most patients agree that trainees enhance the quality of their care and want to contribute to a trainee's education (6,7). Concerns that patients will worry inappropriately should be addressed with more information about teaching hospitals, not less. Trainees are accessible around the clock, often have more time to answer questions, and are closely supervised. Overall, primary teaching hospitals have a lower rate of adverse patient events due to negligence than nonteaching hospitals (8).

Some trainees resort to unfamiliar titles, such as "clinical clerk," that are literally true and avoid the adverse consequences of explicitly calling oneself a student. However, such titles are unacceptable because they are incomprehensible to patients and intended to mislead. "Student physician" is commonly used and emphasizes the special medical training that the student has received.

LEARNING BASIC CLINICAL SKILLS

To learn to take a history, perform a physical examination, draw blood, and start intravenous lines, medical students need to practice on patients. Although patients are not subjected to any serious medical risks, they might be inconvenienced, lose privacy, or experience some discomfort. Out of respect for patients, the attending physician or resident should ask permission first. When asked, almost all patients agree to have students listen to a heart murmur or perform a history and physical examination. Although it is reasonable to ask patients to spend an hour with a student, it is inappropriate to ask them to spend 3 hours for an exhaustive student examination, to miss their meals, or to lose sleep.

LEARNING INVASIVE PROCEDURES

Invasive procedures performed by trainees might raise ethical concerns. In Case 36.1 medical students need practice in order to learn how to perform arterial punctures skillfully. When trainees learn invasive procedures such as lumbar puncture or insertion of central lines, their first patients might experience increased discomfort or even risk. The trainee's self-interest in learning and long-term goal of benefiting future patients might therefore conflict with the short-term goal of providing the best care to current patients.

Trainees frequently do not discuss their participation in invasive procedures with patients (3). One reason for avoiding the issue is the fear that patients will request more experienced physicians (9). Such requests would be understandable. Physicians might consider whether they would be willing to have a trainee perform the procedure on a close relative or whether they would request a more experienced physician.

In the spirit of informed consent, patients need to understand who will be performing invasive procedures and what additional risk, if any, can be attributed to trainees. Such information might be highly pertinent to the patient's decision to undergo a procedure at that institution. For surgical procedures, almost all patients want the attending surgeon to tell them what the resident will do during the operation (6). In one study all obstetric patients believed that student participation should be requested rather than assigned (10). Another study found that patients considered it very important to know that a medical student is going to make the incision, hold retractors, perform rectal or pelvic examinations under anesthesia, suture incisions, or intubate them (9). Patients consider such disclosure more important than medical students do (9).

Attending physicians should tell patients about the participation of students and residents in their care and introduce trainees (6). Patient concerns about unskilled trainees are best resolved by providing more information, not less. When informed and given a choice, most patients allow trainees to do procedures. In one study 80% of patients said they would want to know the experience of the person performing a lumbar puncture (11), but 52% would allow closely supervised medical students to attempt their first lumbar puncture on them and 66% would allow a resident to do so. Patient requests to have a more experienced physician perform the procedure should be honored if possible.

Trainees should carry out procedures only under adequate supervision, except in dire emergencies. Without supervision, the patient might be placed at unnecessary risk and the trainee will not have a good learning experience. The hospital has a responsibility to provide such supervision, and the trainee also has a responsibility to obtain it before starting the procedure. The senior physician should take over the procedure if needed.

LEARNING ON UNCONSCIOUS OR DEAD PATIENTS

Trainees might face further dilemmas when they are asked to learn on unconscious or newly dead patients without explicit consent to do so (12). For example, an attending physician might tell the medical student and intern that they should perform pelvic examinations on a patient under general anesthesia. He says that such examinations provide important learning opportunities because it is easier to palpate the ovaries when the patient is anesthetized. However, pelvic examinations performed under anesthesia without explicit permission violate patient privacy and autonomy (*see* Chapter 41).

Learning invasive procedures on newly dead patients without the next of kin's consent creates similar ethical dilemmas. For instance, after a patient on an intern and student's service dies, the resident might instruct them to practice intubation and insertion of a central venous catheter. "The patient is dead. You can't hurt her, but you might hurt a live patient if you don't practice." Such practice increases skill and thereby benefits future patients (13). However, invasive procedures might be regarded as disfiguring, offensive, or a violation of the corpse's dignity (14). Dead patients are not "teaching material." They deserve to be treated with respect.

Some physicians suggest that practicing invasive procedures should be permitted unless relatives specifically object. However, unless family members are informed that such a practice occurs, they might not know to raise objections (13). A better policy would be to obtain consent from survivors for practicing invasive procedures on newly dead patients (14–16). When consent is sought candidly and compassionately, most family members give permission (17,18). Permission from survivors also helps trainees resolve their own ambivalence or anguish over learning on patients and to appreciate that their training depends on other people's altruism (17).

TAKING TOO MUCH CLINICAL RESPONSIBILITY

Trainees sometimes assume too much decision-making responsibility without adequate supervision (1,2). For instance, a resident on a busy service might tell a subintern to sign his or her name on the physicians' order sheet, saying "You're a good student, and you can page me if you have a real question." However, it is unrealistic to expect the student to distinguish routine orders from serious management decisions. Errors in judgment or dosage can occur even in "routine" orders. Furthermore, the resident is giving the student a mixed message: "Call me for serious problems, but if you're a good student you won't bother me." Discouraging trainees' questions also reduces opportunities for learning. Students who request adequate supervision implicitly criticize the resident and might experience retaliation in grades and evaluations. They might be labeled as "not a team player," "insecure," "incompetent," or "reluctant to assume responsibility."

The training system might place the student in an untenable situation by exerting pressure to take too much responsibility or failing to set clear expectations or provide sufficient supervision. The institution should clarify expectations for supervision of trainees and establish a mechanism for students as well as residents to ask for help. A satisfactory resolution might require system-wide changes, such as more involvement from the attending physician or transfer of some patients to another team.

Trainees are ultimately accountable for taking too much responsibility and placing patients at increased risk. Ethically, trainees need to know their own limitations and should not exceed them.

LIMITS ON WORK HOURS

Residency accreditation bodies have enacted limits on house staff work hours in order to prevent fatigue and burnout and reduce medical errors. However, strictly observing such limits might raise ethical dilemmas.

CASE 36.3 House staff work hours.

During an on-call night, an intern has admitted only two patients. After rounding, he has finished his 30-hour tour-of-duty and is checking out when he gets paged. A 78-year-old woman that you admitted with pyelonephritis now has a temperature of 39 C, a blood pressure of 100/60, a pulse of 110, and seems confused. The cross-covering intern appears stressed. She exclaims, "Look, I've already had four admissions. How can you dump a patient like this?"

In Case 36.3 the harried cross-cover intern accuses her colleague of "dumping" a patient. This term highlights the way in which stressed physicians might focus their attention on their own well-being rather than the patient's interests. Ironically, restrictions on house staff work hours were intended to reduce stress on physicians. The intern signing out might feel that he should help his colleague by staying longer. After all, he might be overwhelmed some day and need similar help. In this case he does not feel tired. Moreover, the patient in early septic shock needs timely attention. It is commendable to help colleagues during unexpected emergencies. However, the on-call systems should anticipate that house officers on call might be overwhelmed. The interns should be able to call on the resident, the attending physician, or a "float" for help. In the long run, asking busy interns to stay additional hours to help others only leads to more stress and fatigue and ultimately greater risk for patients. In this case the intern at the end of shift might say, "Boy, you are really getting hit. Let me try to help. I can sign her out to the resident, who can start antibiotics and stabilize her. I sure hope it lightens up later for you." In this way the outgoing intern need only spend a few extra minutes, the cross-cover physician will feel less stressed, and, most important, the patient will receive care promptly.

In other cases a resident can provide an irreplaceable benefit to a patient or family by working a little longer than the scheduled hours. For example, a resident might be in the middle of a discussion about withdrawing life-sustaining interventions or comforting a family member over a patient's death. It would be desirable for the resident to stay to finish the conversation before signing out to the covering physician. In this situation the rapport and understanding that the physician has developed with the patient or family is not readily transferred to another doctor. Moreover, such rapport is the essential component of care in these end-of-life situations. Under such circumstances strict adherence to the time clock would undermine the ideals of benefiting patients and acting with compassion. However, such situations should remain exceptions and should not create any expectation that trainees should routinely exceed limits of working hours.

RELATIONSHIPS WITH COLLEAGUES

Case 36.3 illustrates how helping stressed colleagues is altruistic and helps create mutual expectations of reciprocity. Ultimately patient care is also enhanced when physicians support and help each other.

CASE 36.4 Lying or equivocating on rounds.

A 54-year-old man is admitted with severe pancreatitis. Overnight he required large volumes of fluid in order to maintain his blood pressure. While the intern is presenting the patient on rounds, the attending physician asks, "So what happened to his calcium?" The intern remembers that calcium is an important prognostic factor that should be followed in pancreatitis. Although he checked the patient's laboratory tests, the intern cannot remember whether he specifically reviewed the calcium. He thinks he would have noticed if the calcium had not been normal.

In Case 36.4 the intern feels a tension between making a good impression on the attending physician and acting for the patient's good. If the intern says that the calcium was normal when

it was not, the subsequent plan of care might be inappropriate. Hence, the ethical analysis is clear: The intern should say exactly what he did and offer to verify the value at the nearest computer terminal.

However, it would be simplistic to view this situation only as a clash between self-interest and beneficence. The hospital and team's culture is important. If the attending physician tends to criticize trainees sharply, the intern will be deterred from telling the truth. Conversely, if a resident and attending physician can reinforce the value of truth-telling by stopping rounds to look up the value and by discussing why the calcium level is important in this case, it will encourage the intern to tell the truth.

Moreover, a teaching style that leads interns to feel stressed might be counterproductive. Slips in which a person forgets something are to be expected. Usually they are due to the limits of human cognition, not carelessness. Exhorting interns to be more careful or by shaming them to teach them a lesson cannot remedy slips; instead, interns need help in developing a routine for keeping track of labs or a checklist to ensure that essential tasks are carried out.

UNETHICAL BEHAVIOR OR SUBSTANDARD CARE BY OTHER PHYSICIANS

Trainees might be involved in cases in which senior physicians appear to violate ethical guidelines (19).

CASE 36.5 Failure to obtain informed consent for sterilization.

An attending obstetrician performs a tubal ligation on a 32-year-old Latina woman on Medicaid who has just delivered her sixth child by cesarean section. According to the chart the patient refused sterilization at her last prenatal visit. The resident who delivered the baby and served as the translator for the patient is outraged. The delivery room nurse confirms that no informed consent was obtained but cautions, "Don't ruin your career over this."

Some disagreements reflect reasonable differences of clinical judgment or misunderstanding by the trainee. In Case 36.5, however, the attending physician is violating the ethical guideline of respecting patient autonomy as well as laws on informed consent. The resident felt outraged at the event, frustrated at being powerless, guilty that she did not intervene, and ashamed that she had become an accomplice in an unethical deed. She believed that the attending physician's action was both sexist and racist.

Trainees who are involved in a patient's case might also observe grossly substandard care by senior physicians, as when they fail to round on patients, write progress notes, or answer pages. In cases of clearly inadequate care, the trainee has an ethical obligation to protect patients and to not mislead them. In addition, there is an ethical obligation to try to prevent harm to future patients if a pattern of impairment exists (*see* Chapter 35). However, there are also strong countervailing pragmatic considerations, as we discuss next.

RISKS TO WHISTLEBLOWERS

Fear of retaliation is a legitimate practical concern for trainees (20). The obstetrics resident in Case 36.5 might receive a bad evaluation or unfavorable treatment during the rest of her training. As in all occupations, whistleblowers might suffer harm even if their accusations prove valid. Ideally, the patient's well-being should take priority over the trainee's self-interest. Individual trainees need to decide how much personal risk as a whistleblower they are willing to accept relative to the harm they might prevent.

SUGGESTIONS FOR TRAINEES

Involve Other Physicians

Trainees often feel that they have to resolve these troubling situations by themselves. However, they should discuss the situation with trusted colleagues and senior physicians. These discussions allow trainees to verify that they have observed unethical misconduct or markedly substandard care and not that they merely have a reasonable difference of clinical judgment. Such reality testing is often

crucial for their peace of mind and sense of integrity. In addition, other people might provide emotional support, give advice, and intervene constructively. The chief resident, clerkship or residency director, and chief of service have an obligation to address issues of unethical or incompetent behavior (20). Furthermore, every hospital should have procedures, such as quality assurance programs or a patient ombudsperson, for investigating such cases (20).

Decide What to Tell the Patient

In addition to informing appropriate senior physicians, the trainee needs to consider what to tell patients, if anything. There are strong reasons why patients should have truthful information about events that will affect their future medical care and life plans. The sterilized woman in Case 36.5 cannot make informed decisions about reproduction if she does not know that a tubal ligation was performed.

Trainees do not need to inform the patient personally if they inform some responsible senior physician, such as the chief of service. However, trainees need to answer truthfully if the patient asks the trainee directly what happened.

Protect Their Own Interests

If the harm to patients is serious, the ethical ideal is for trainees to fulfill their obligations to patients, even at some risk to their careers. However, trainees should also minimize risks to themselves. Measures such as writing an angry note in the chart or directly accusing the attending physician of being unethical are likely to inflame the situation. Involving more senior physicians can reduce the risk of reprisals. Trainees who are unwilling to be identified as accusers can still discuss episodes with the quality assurance committee or chief of staff. In this way, if other people are willing to come forward there will be corroborating evidence. In addition, trainees should keep records of how they raised their concerns.

In summary, medical students, house officers, and fellows face unique clinical dilemmas. Trainees' interests in learning clinical medicine and invasive procedures might conflict with patients' interests. In addition, the ethical guideline of preventing harm to patients might conflict with trainees' career advancement. The ethical ideal is for all trainees to act in patients' best interests, even at some personal risk or disadvantage.

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SECTION VI

Ethical Issues in Clinical Specialties

CHAPTER 37

Ethical Issues in Pediatrics

Children are immature, they depend on their parents or guardians emotionally and financially, and they cannot make informed decisions about their own care. Therefore, decisions should be made differently in pediatrics than in adult medicine.

HOW ARE ETHICAL ISSUES IN PEDIATRICS DIFFERENT?

CHILDREN ARE NOT AUTONOMOUS

Because children cannot weigh risks and benefits, compare alternatives, or appreciate the long-term consequences of decisions, they are incapable of making informed decisions. Hence, autonomy is less important in pediatrics than in adult medicine. Children's objections to beneficial medical interventions do not have the same ethical force as adults' informed refusals. Because children are immature and vulnerable, they need an adult to make decisions for them and to look after their best interests. Parents are presumed to be the appropriate decision-makers (1).

Children must be protected from the consequences of unwise decisions by themselves or by others. Indeed, it is tragic if a child dies or undergoes serious harm because a simple, effective medical treatment was not provided.

PHYSICIANS SHOULD BE ADVOCATES FOR CHILDREN

Doctors are in a unique position to identify situations in which parental decisions or children's actions jeopardize children's health and well-being. Pediatricians are given special responsibilities in these situations because if they do not intervene, children might suffer serious, long-lasting harm.

PHYSICIANS SHOULD RESPECT CHILDREN'S POTENTIAL TO BECOME AUTONOMOUS ADULTS

Although young children are not autonomous, their potential autonomy as future adults deserves respect. Parents mold children, and parental values deserve great deference. However, when children reach maturity they might choose values that differ from those of their parents. Physicians need to help ensure that parental decisions do not close off a child's open future as a unique person.

As children grow, they become capable of making informed decisions and their involvement in care should increase. Pediatricians need to provide children with information about their conditions and opportunities to participate in decisions about their care, to the extent it is appropriate developmentally (1).

WHAT STANDARDS SHOULD BE USED IN MAKING DECISIONS FOR CHILDREN?

Because children cannot make informed decisions, beneficence or the child's best interest is the primary ethical guideline in pediatrics.

CHILDREN'S BEST INTERESTS

The concept of "best interests" emphasizes that children are persons separate from their parents, with their own interests and rights. In most situations parents' decisions and their ongoing involvement in children's care promote children's best interests. However, children's "best interests" are often difficult to interpret. People might disagree over which factors comprise a child's best interests, which outcomes and risks are acceptable, and how to weigh the benefits and burdens of interventions. Promoting some of the child's interests might set back other interests.

A child's best interests include both the duration and quality of life. However, although quality-of-life judgments seem unavoidable, they might be ethically problematic. It is difficult to predict a child's future quality of life. Healthy people tend to underestimate the quality of life of persons with chronic illness. Some people believe that Down syndrome is a fate worse than death, but children with this condition can experience happiness and parents often prize them. Chapter 4 discusses best interests in detail.

CHILDREN'S PREFERENCES

To the extent that children have the capacity to make informed decisions about their medical care, their choices should be respected. Chapter 10 discusses how to determine whether a patient has the capacity to make medical decisions.

Even when children are not capable of giving informed consent, their assent to interventions is still ethically important. It is disturbing to force interventions on children who are actively resisting them. A child's objections are not necessarily decisive. For instance, a child who objects to shots should still receive immunizations. However, forced therapy becomes more ethically problematic if children are older, the effectiveness of the intervention is less clear, or the side effects are more common, more serious, or longer lasting. The pediatrician should listen to and respond to the child's reasons for dissenting from treatment. If interventions are carried out despite the child's objections, it is appropriate for the pediatrician to offer an apology to the child (2).

PARENTS' AND FAMILY MEMBERS' INTERESTS

Although the child's best interests are of primary concern, parents and other family members have interests that must also be taken into account. What is best for an individual child can be understood only in the context of what is best for the family as a whole or for other family members. Parents cannot be expected to devote all their energy and resources to one child even though they should be expected to make some sacrifices. For example, parents might choose not to buy a house in the best school district but instead live closer to their jobs.

WHO SHOULD MAKE MEDICAL DECISIONS FOR CHILDREN?

THE PRESUMPTION OF PARENTAL DECISION MAKING

Parents are presumed to be the appropriate decision-makers for their children. Generally, love motivates them to do what is best for their children. In addition, parents have long-term relationships with and obligations to their children. In most cases parents concur with pediatricians' recommendations—for example, agreeing to antibiotics for strep throat, bronchodilators for asthma, and surgery for appendicitis.

American culture prizes parental responsibility, family integrity, and strong parent–child relationships. Parents or guardians have considerable latitude, but not complete discretion, in raising children. Within limits set by society, parents have discretion to inculcate their values in children and to make choices for rearing their children. For example, children must attend school but parents may choose the type of school.

Pediatricians speak of parental permission rather than consent in order to distinguish what people may decide for themselves from what they may decide for their children. Although informed adults have a right to refuse any medical intervention, parents do not have absolute power to refuse care for their children (1,2).

Emergencies

In an emergency, when a parent or guardian is not available and delay in treatment would jeopardize the child's life or health, the physician should provide appropriate treatment without parental permission (3). The rationale is that it would violate the child's best interests to delay emergency treatment until approval is obtained.

Exceptions to Parental Decision Making

Some parents might be estranged from their children or unwilling to be involved in their care. Other parents lack the capacity to make informed decisions because of alcohol or substance abuse, developmental disability, or irresponsibility. Strictly speaking, parents should make decisions for children unless a court has appointed someone else as guardian. The court process, however, might be too slow for medical decisions to be made promptly. In practice, physicians often make informal arrangements for another relative to make decisions when parents are absent or incapable of making decisions.

Disagreements Between Parents and Pediatricians

Pediatricians are understandably distressed when parents make medical decisions that are not in the child's best interests or when a child's care at home is deficient. Doctors need to try to persuade parents to accept effective interventions that have few side effects. Chapter 4 offers specific suggestions on how to resolve such disagreements. In addition, physicians, together with social workers and nurses, can mobilize emotional support and social resources to help the parents provide better care.

In rare situations physicians should ask the courts to override parental decisions—for example, when parents cannot be persuaded to accept life-saving therapy that has few side effects, such as antibiotics for bacterial meningitis in a previously healthy child.

Overriding parents through the courts, however, should be a last resort (4). Lifestyles that physicians might find objectionable, such as alcohol abuse or a disheveled home, do not in themselves constitute neglect. Even if a child with asthma or diabetes is not receiving medications regularly, disrupting the parent–child bond causes emotional distress for the child. Foster placement or institutionalization might be worse for the child than care from well-meaning parents who are trying to cope with difficult circumstances.

THE ADOLESCENT PATIENT

As children mature they develop the capacity to make informed decisions about their health care. By statute, adolescents 18 years old may give informed consent or refusal to medical care without parental involvement in almost all states. The law might also allow younger minors to make their own decisions about health care in some circumstances (5,6). State laws regarding the medical care of adolescents attempt to accommodate several conflicting policy goals, such as fostering access to treatment for important public health problems, respecting adolescents who are functionally adults, and encouraging parental involvement in their children's care. Because statutes vary both from one state to another and from one medical condition to another, pediatricians need to be familiar with the laws in their jurisdiction.

Mature Minors

"Mature minors" are capable of giving informed consent. Ethically, mature minors should be allowed to consent to or refuse medical treatment, just as adults can. Pediatricians need to evaluate adolescents' capacities to give informed consent and to help them obtain appropriate support from parents or other adults. Physicians need to assess an adolescent's understanding of the proposed intervention, the alternatives, the risks and benefits of each, and the likely consequences. Generally adolescents over 14 or 15 have such decision-making capacity, but younger children often have difficulty entertaining alternatives, appreciating the consequences of decisions, and appraising their future realistically. In most states a court must declare an adolescent a mature minor.

Emancipated Minors

Adolescents who are living apart from parents and managing their own finances, are married, have children, or have served in the armed forces are termed "emancipated" minors. Most states regard them as *de facto* adults capable of consenting to their own medical care. Some states require a judicial hearing and declaration of emancipation by the courts.

Treatment of Specified Conditions

Most states allow minors to assent to treatment without parental permission for sensitive conditions, such as sexually transmitted diseases (STDs), contraception, pregnancy, sexual assault, substance abuse, and psychiatric illness (7–9). The rationale is not that adolescents who seek treatment for such conditions are making informed decisions. Indeed, these conditions might impair judgment or result from unwise choices. Instead, the justification is that requiring parental permission would deter many adolescents from seeking treatment for important public health problems. As discussed later in this chapter, even when adolescents consent to such care themselves, it is generally in their best interests to involve their parents in their subsequent care.

Parental Requests for Treatment

Parents might request that the physician test an adolescent for illicit drug use or pregnancy without telling the child (10). Although concern generally motivates such requests, surreptitious testing is unacceptable because it violates the adolescent's emerging autonomy, undermines trust in the physician, and compromises future care.

THE PEDIATRICIAN'S RELATIONSHIP WITH CHILDREN AND PARENTS

Disclosing of information to children, protecting confidentiality, and truth-telling might raise ethical dilemmas. These actions are important because they show respect for children, lead to beneficial consequences, and foster trust in the medical profession.

DISCLOSURE OF INFORMATION TO CHILDREN

To obtain assent from children, pediatricians need to provide them with pertinent information in terms that they can understand. Children who do not want information or cannot understand medical details might still want to know what will be done to them.

Some parents do not want their children to know about serious diagnoses, such as cancer or human immunodeficiency virus infection (11). Pediatricians should elicit the parents' concerns and fears. Parents might believe that the child will not be able to handle bad news or that peers will reject the child. Physicians can explain how children might cope better, have fewer psychosocial problems, and adhere more closely to treatment if they understand their diagnosis and the proposed therapy. Parental requests for secrecy are particularly difficult when adolescents are capable of making health care decisions. Generally, physicians can persuade parents to allow disclosure of information to the child, provide developmentally appropriate information, and help the child cope with the news.

Physicians should never promise parents that the child will not learn about the diagnosis. Other members of the health care team might disclose that information. In addition, pediatricians should give forthright answers when children ask directly about their diagnosis. Deception would compromise the physician's integrity and patients' trust in the medical system.

CONFIDENTIALITY

As Chapter 5 discussed, confidentiality is not absolute. Pediatrics presents several unique issues involving confidentiality.

Exceptions to Confidentiality

Physicians and other health care workers must report cases of suspected child abuse or neglect to child protective services agencies. Parents' and children's privacy is overridden in order to protect vulnerable children from a high likelihood of serious harm. To be justified in reporting a case, physicians do not need definitive proof of abuse and neglect, only sufficient information to warrant

a fuller investigation. In evaluating possible cases of child abuse, pediatricians should treat parents with respect, keeping in mind that most parents are trying their best to deal with a difficult situation. Intervention might enable parents to obtain enough assistance and support to prevent further abuse. In extreme cases protective service agencies may remove the child from parental custody.

Disclosure to Schools

Pediatricians might need to disclose health information to schools. Whenever information is disclosed, physicians should disclose only information that is truly needed. For example, a school need not know the diagnosis but only know that the child's absence was medically indicated. Pediatricians might also need to arrange for the child to receive medications at school. It is useful for pediatricians to discuss how parents, the child, and school personnel might respond to inquiries about the child's health in ways that maintain confidentiality.

Adolescents

Adolescents might wish to keep certain information confidential from their parents—for instance, that they are receiving care for mental health, STDs, pregnancy, or substance abuse (7,12). Assurances of confidentiality increase the willingness of adolescents to disclose sensitive information to physicians and to seek health care (9). Pediatricians should routinely discuss confidentiality with adolescents and offer them an opportunity to talk privately, apart from parents.

Many physicians provide absolute rather than conditional assurances of confidentiality, and such unconditional assurances increase adolescents' willingness to return for future care (13). However, as Chapter 5 discussed, overriding confidentiality is ethically appropriate and legally mandated in several situations. Moreover, most adolescents themselves believe that confidentiality should be overridden when a patient plans to commit suicide or has been physically or sexually abused (14). Physicians should not promise more than they can deliver. Hence, physicians should explain that confidentiality is not absolute and that exceptions are made, but only in limited situations (7).

Even when adolescents are allowed to consent to treatment for sensitive conditions, parents' involvement in their subsequent care will generally be beneficial. State laws vary on whether the physician may or must inform parents of the patient's care (5,6). Laws also vary according to the condition being treated, as Table 37-1 illustrates. For some sensitive conditions physicians are required to notify parents or are permitted (but not required) to do so. In other conditions physicians are prohibited from so informing parents without the minor's consent, and in still others doctors may use their judgment about disclosing to parents. When disclosure is mandated, laws generally allow an exception when the physician believes that disclosure will harm the patient.

TABLE 37-1

California Laws Regarding Notification of Patients after an Adolescent Has Consented to Treatment (15)

Condition	Requirement
Pregnancy, birth control, or STDs	May not inform parents unless the adolescent consents
Sexual assault	Must inform parents unless parent committed assault or rape
Drug or alcohol abuse	Must involve parents in care unless physician considers involvement inappropriate However, in federally funded programs, may not inform parents unless the adolescent consents
Minors living apart from parents and managing own finances	May notify parents
Emancipated minors who are married or in the armed forces	May not inform parents unless the adolescent consents

Because these laws are complex, physicians might need to consult a specialist in adolescent medicine or the institution's legal counsel.

Generally, physicians should encourage adolescents to discuss medical decisions with their parents, who usually provide useful support and advice (7). It is often impossible to keep the parents from learning about the child's condition because of the condition's nature, the practicalities of obtaining treatment, or the payment for care. Doctors can offer to help adolescents disclose information to their parents. In some situations, however, disclosure might be counterproductive or dangerous, as when domestic violence is likely. In such situations it might be best for the child to confide in a trusted adult relative.

REFUSAL OF MEDICAL INTERVENTIONS

The physician's response to parents' refusal of treatment will depend on the clinical circumstances, the benefits and burdens of treatment, and, in some cases, on the child's wishes (16).

REFUSAL OF INTERVENTIONS OF LIMITED EFFECTIVENESS OR GREAT BURDENS

Parents may refuse interventions that have limited effectiveness, impose significant side effects, require chronic treatment, or are controversial. In such situations the parents' informed refusals should be decisive. Refusal of such interventions might be ethically appropriate even if the patient's life expectancy might be shortened.

REFUSAL OF EFFECTIVE INTERVENTIONS WITH FEW SIDE EFFECTS

Parents sometimes refuse treatments for life-threatening conditions even though these treatments are highly effective in restoring the child to previous health, are short term, and have few side effects (17). For example, Jehovah's Witnesses commonly refuse blood transfusions for children who undergo major trauma. Similarly, Christian Scientist parents often refuse antibiotics for bacterial meningitis. Physicians who are unable to persuade parents to accept such interventions should seek a court order to administer the treatment (18). A court order is important because it signifies that society believes that the parent's refusal is unacceptable. As one court declared, although "parents may be free to become martyrs themselves," they are not free to "make martyrs of their children (19)."

In some situations physicians defer to parental refusals of effective, safe interventions because conflict between the parents and the medical system would harm the child. For instance, some parents object to immunizations because of religious objections, concerns about side effects, or opposition to modern medicine. Immunizations are required for entrance into school, although many states allow parents to refuse on the basis of religious or other objections. Even when no exceptions are permitted, requirements for immunization might not be enforced. If the number of unimmunized children is small and herd immunity exists, it might not seem worth alienating the parents. However, if an epidemic does break out, public health officials rapidly enforce requirements for immunization.

REFUSAL OF EFFECTIVE THERAPY WITH SIGNIFICANT SIDE EFFECTS

The most difficult decisions involve interventions that are highly effective in serious illness but also highly burdensome, such as bone marrow transplantation in acute lymphocytic leukemia or combination chemotherapy in testicular carcinoma. In this situation the child's preferences might be important. If an older child or adolescent makes an informed decision to undergo such treatment, physicians should support that decision.

If parents continue to refuse such therapy after repeated attempts at persuasion, some physicians seek court orders to compel treatment. In doing so, physicians need to take into account the impact on long-term parental cooperation with the child's care. At the very least, physicians should listen to the parents' objections and show respect for their opinions and ongoing responsibility for the child.

CHILD'S REFUSAL OF INTERVENTIONS

In some cases children might refuse effective treatments. The physician's response should depend on the seriousness of the clinical situation, the effectiveness and side effects of treatment, the reasons for refusal, the parents' preferences on treatment, and the burdens of insisting on treatment. It is difficult to force adolescents to take ongoing therapies, such as insulin shots for diabetes or inhalers for asthma. The most constructive approach is to try to understand the patient's reasons for refusal, to address them, and to provide psychosocial support. In several cases adolescents have run away from home rather than accept cancer chemotherapy that has significant side effects (20). Because it is physically difficult as well as morally troubling to force such treatment on adolescents, these refusals have been accepted, particularly when the parents have supported the child's refusal.

HANDICAPPED INFANTS

The federal Child Abuse Amendments of 1984 and subsequent regulations, commonly called "Baby Doe Regulations," apply to decisions to withhold medical treatment from disabled infants less than 1 year old. Their intent is to ensure such interventions as surgery for duodenal atresia or tracheal-esophageal fistula in infants with Down syndrome. They limit the circumstances in which interventions may be withheld. Under these regulations, treatment other than "appropriate nutrition, hydration, or medication" need not be provided if (a) the infant is irreversibly comatose, (b) treatment would merely prolong dying, (c) treatment would not be effective in ameliorating or correcting all life-threatening conditions, (d) treatment would be futile in terms of survival, or (e) treatment would be virtually futile and would be inhumane. Decisions to withhold medically indicated treatment might not be based on "subjective opinions" about the child's future quality of life. In addition, hospitals are encouraged to establish ethics committees, called *infant care review committees*, to advise physicians in difficult cases.

The Baby Doe Regulations have been sharply criticized (21). Many terms, such as "appropriate" and "futile," are subject to conflicting interpretations. Parents are not included in decision making despite their customary role as surrogates. Commentators point out that the regulations are often not literally followed or strictly enforced. Physicians should appreciate that these regulations do not require physicians to provide treatment that, in their judgment, is inappropriate.

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CHAPTER 38

Ethical Issues in Surgery

Surgery differs from other specialties in clinically significant ways. First, surgeons intentionally cause short-term injury in order to achieve longer-term therapeutic goals. Patients undergo operative risks, experience pain, and emerge with scars. Although all medical interventions involve risk, many of surgery's side effects are certain rather than possible and occur before any benefit can be realized. Second, patients turn over control of their bodies to the surgical team. Events in the operating room are out of the patient's and family's view. Third, operations are not standardized in the sense that drug therapies have standard dosages. The surgeon's technical competency, judgment, experience, and confidence are crucial. Individual surgeons vary in their choice of incision, use of electrocautery and stapling, and selection of suture material or implanted devices. In an individual patient the surgeon might need to modify the operative approach because of anatomic variation. This chapter discusses how these distinctive clinical characteristics of surgery have important ethical implications.

HOW ARE ETHICAL ISSUES IN SURGERY DIFFERENT?

Several ethical guidelines are particularly salient in surgery.

First, acting in the patient's best interests takes on added importance because patients are completely dependent on the surgical team during operations. Patients cannot look out for their interests during surgery and neither can a family member or proxy.

Second, informed consent is especially important because surgery is a major bodily invasion. Some operations, such as mastectomy, colostomy, or amputation, dramatically alter patients' body image, sense of self, and daily functioning. Patients differ in what surgical risks they are willing to accept.

Third, learning procedural skills differs from learning cognitive skills. More senior physicians can supervise decision-making by trainees so that the risk of mistakes is greatly reduced. However, with procedural skills, the trainee has manual control of the procedure and can make a mistake before the supervising surgeon can intervene. After surgeons complete residency or fellowship, they need to learn new techniques, such as laparoscopic procedures, with little formal training.

Fourth, individual surgeons are held responsible for the outcomes of surgery. Deaths in the operating room or after surgery raise the question of whether the surgeon erred in judgment or technique. Postoperative deaths need to be reported to the coroner. After a serious adverse event, in surgical morbidity and mortality conferences surgeons must justify why they operated and how the case was managed (1). Increasingly, surgeon-specific clinical outcomes are tracked and made available to the public or insurers. Moreover, surgeons feel personally responsible for outcomes because of their "hands-on" involvement in care.

INFORMED CONSENT IN SURGERY

Patients need information that is pertinent to their decision to have an operation. As part of the informed consent process, surgeons need to discuss information about the operation, the benefits and risks, the likely consequences, and the alternatives.

DISCLOSURE OF ALTERNATIVE APPROACHES

Evidence-based medicine has demonstrated that for some conditions several options have similar outcomes. In benign prostatic hypertrophy, transuretheral resection of the prostate, medical treatment, and watchful waiting are all acceptable approaches. For localized breast cancer, lumpectomy followed by radiation offers survival rates similar to more extensive surgery with less disfigurement. A number of states legally require that women with breast cancer be informed of breast-conserving treatments (2). The importance that the patient places on side effects of different approaches will be decisive. Hence, the surgeon should discuss all standard options with the patient even if the doctor believes that one is superior. However, surgeons do not need to discuss alternative or unconventional therapies whose effectiveness has not been demonstrated or that a respected subset of physicians has not adopted.

DISCLOSURE OF THE OUTCOMES AND EXPERIENCE

For some operations low-volume hospitals and surgeons have markedly higher surgical mortality rates (3,4). Thus, the surgeon's experience with the operation is information that reasonable patients might consider relevant when selecting a hospital or surgeon. For major elective operations, patients might want to select a hospital or surgeon with low morbidity and mortality rates. Hence, surgeons should discuss with patients their experience and outcomes with an operation when outcomes for the procedure vary substantially by provider and by experience (5–7). This ethical obligation rests on both respecting patient autonomy and acting in the patient's best interests.

Provider-specific outcomes might be publicly available. New York State and Pennsylvania publish risk-adjusted hospital-specific and surgeon-specific outcomes for coronary bypass surgery. Surgeons might object to public disclosure of such outcomes data because of concerns about risk adjustment, random variation in relatively small samples, and changes in personnel or procedures. However, the antidote is for surgeons to provide more explanation to patients, not to withhold information.

Experience might also be an issue in teaching hospitals because of residents' and students' roles. In fact, outcomes in teaching hospitals have better outcomes for complex operations than nonteaching hospitals (8). Patients should be informed of trainees' role during surgery and how they will be supervised (7). Patients usually consider it very important to be told that a resident or a medical student is going to make the incision, hold retractors, perform rectal or pelvic examinations under anesthesia, or suture (9,10). Furthermore, patients consider such disclosure more important than medical students do (9). The faculty surgeon might say. "Dr X is a senior resident and will be performing portions of your operation; I will be assisting and supervising Dr X throughout (11)." Almost all patients also want to meet the resident before the operation (10). Patients generally respond favorably to having trainees participate in operations, and most patients believe that residents are adequately supervised and can respond quickly if complications develop, although patients also realize that inexperience in residents might lead to substandard care (10).

Disclosure is also an issue when experienced surgeons learn new techniques, such as laparascopic surgery (7). Initially, complication rates are higher with laparascopic procedures than with open techniques and operating times are longer. When surgeons get more experience, complication rates become comparable to those of open procedures. For patients it might be important to know a surgeon's experience with a new technique, particularly if the outcome would be significantly better with a more experienced surgeon. However, surgeons might be concerned that patients who learn that they are inexperienced with a technique will not trust them to do the operation.

CHANGES IN THE OPERATION CAUSED BY UNANTICIPATED FINDINGS

A surgeon might encounter unexpected findings that require a substantially different operation than was discussed during the informed consent process. For example, suppose that during a cholecystectomy, the surgeon finds a gastric mass that is suspicious for carcinoma. Should the surgeon biopsy the mass, and if so, should the surgeon resect the tumor if the biopsy shows carcinoma? The surgeon might believe that an opportunity to cure gastric carcinoma might be missed if biopsy and resection are not done. Furthermore, a second operation would subject the patient to additional risk. On the other hand, the patient might be shocked to find that the surgeon performed a more extensive operation than discussed even if the surgeon did so in order to benefit him.

How can surgeons resolve this dilemma between acting for patient's good and respecting the patient's autonomy? Some surgeons seek blanket consent to change the operation if unexpected findings occur. However, this contingency is so rare that it is not efficient to discuss it with all patients preoperatively. A sound approach is to contact the next of kin in the waiting area. If the family agrees with the surgeon's recommendations, the patient's best interests and autonomy are both served. It would also be acceptable to carry out the biopsy if the family cannot be immediately located and to resect the mass only if a family member's consent can be obtained.

Such cases of incidental findings need to be distinguished from cases in which the operation needs to be changed because of a complication. For instance, a surgeon might nick the spleen and a splenectomy might be required to control bleeding. In this instance the surgeon should proceed with splenectomy and explain to the patient after the operation that a splenectomy was done because of the intraoperative complication.

MAY A SURGEON DECLINE TO OPERATE?

In some cases a surgeon might determine that an operation is not indicated because the risks of surgery greatly outweigh the possible benefits (12). What should the surgeon do if the patient or referring physician insists on surgery? Different reasons for not operating need to be distinguished. Some reasons are patient-centered. The surgeon might believe that an operation will not benefit the patient. For instance, a patient with chronic abdominal pain might believe that the pain is caused by gallbladder disease and seek a cholecystectomy (12). However, if there is no objective evidence of gallstones, the surgeon might conclude that a cholecystectomy would be futile in a strict sense and decline to operate (*see* Chapter 9).

In other situations the surgeon might judge that although the operation is not futile, the risks are prohibitive, as the following case illustrates.

CASE 38.1 Decision to not operate in a very high-risk patient.

A 64-year-old man admitted for a myocardial infarction continues to have chest pain, ischemic changes on his cardiogram, and congestive heart failure. He is found to have multiple diffuse coronary lesions that cannot be revascularized. He also develops a urinary tract infection from a Foley catheter. Despite antibiotics, he subsequently develops pyelonephritis, intrarenal abscesses, and septic shock. The patient becomes confused and unable to participate in decisions. Percutaneous drainage guided by computed tomography is not feasible. The family appreciates that the surgery is very risky, but they believe it offers the patient the only chance of survival. However, the surgeon believes that the patient's coronary disease is so unstable that he is unlikely to survive an open procedure.

Surgeons are traditionally permitted great discretion not to operate when they determine that surgery would not be in the patient's best interests. Surgeons often justify a refusal to operate by the shorthand declaration, "This patient is not a surgical candidate." Such surgical decisions are rarely challenged and discussed, but internists' unilateral decisions to withhold medical interventions are often extensively debated.

Is there an acceptable ethical basis for this distinction between surgeons and internists? Surgeons are considered more responsible for the harmful consequences of operations than internists are for the harmful effects of drugs they prescribe. In both situations the physician is responsible for the recommendation to carry out an intervention or not. However, making a surgical incision

causes much more certain and direct harm to the patient than writing a prescription does. Furthermore, because surgery requires manual manipulations, it is undesirable to require surgeons to perform operations they consider inadvisable. An operation by an unwilling surgeon might place the patient at additional risk because of lapses of concentration or lack of confidence.

Surgeons need to appreciate that patients have different thresholds for risk. Some might accept severe short-term harms and unfavorable odds of success. Surgeons should decline to operate only if the risks are dramatically greater than the likely benefits, as opposed to only slightly increased. Surgeons must guard against misrepresenting information to patients because of their own bias. For example, they should never overstate an operation's risks because they recommend against it. Furthermore, they must be careful to base decisions on medical outcomes, not their personal judgments that the patient's quality of life is unacceptably poor.

Other reasons for not operating might be surgeon-centered. In some cases surgeons question whether the risk of contracting human immunodeficiency virus (HIV) infection or hepatitis C during an operation is acceptable in view of the limited benefits to the patient. For example, an orthopedic surgeon might believe that a total hip replacement on a patient with the acquired immunodeficiency syndrome presents an unacceptable risk of occupational HIV infection because bone fragments might penetrate even a double layer of gloves. In other cases a surgeon might be reluctant to take on complex, high-risk cases that might worsen their complication rates or length of hospital stays or make it more difficult to secure contracts from managed care organizations. Yet another factor might be unreimbursed care (12). Surgeons might believe that they have accepted more than their fair share of charity cases. In these situations the surgeon's self-interest must be acknowledged as a natural and legitimate concern. However, they must be put into perspective and addressed directly. Ultimately, the ethical ideal is for physicians to make patients' best interests paramount if they can do so without a grave setback to their own self-interest. To clarify patients' best interests, surgeons can consider what they would recommend if the patient did not have HIV infection (but another disease with a similar prognosis) or had good health insurance.

Some patients decline an operation recommended by a surgeon, choose to have surgery by someone else, and after an unsatisfactory outcome return to the first surgeon to request that the complications be fixed. In deciding whether to operate in such a case, surgeons need to be aware of their feelings, which might include anger, resentment, and pride and which might stand in the way of objective judgment. Surgeons have the option of not reestablishing the doctor–patient relationship in this situation. In many cases it will be desirable to refer patients to colleagues who can start afresh without qualms. In contrast, surgeons would be responsible for addressing the complications of an operation that they had performed.

REQUESTS TO CARRY OUT SURGERY IN WAYS THAT INCREASE RISK

Patients might consent to an operation but refuse specific interventions or techniques. Such restrictions might make their operation riskier and more complicated. These decisions need to be distinguished from patient refusals of the operation itself.

CASE 38.2 Emergency surgery on a Jehovah's witness.

A 54-year-old Jehovah's Witness is admitted after a motor vehicle accident with a ruptured spleen, a hemoglobin of 6%, hypotension, chest pain, and ischemic changes on electrocardiogram. He refuses blood transfusions but agrees to surgery, understanding that he might die without transfusions. The surgeon declares, "I accept his right to refuse transfusions, but he can't make me operate with one hand tied behind my back."

In this case the patient has a clear indication for splenectomy. In this patient's religion, surviving the accident is less important than avoiding the taint of transfusions, which would result in everlasting damnation (*see* Chapter 11). Operative risk increases with more severe anemia, reaching 33% when hemoglobin falls below 6 g per dl (13). Severe anemia also places this patient at greater risk for myocardial infarction and renal failure. The hospital course will be more complicated without transfusion support, and the length of stay and overall cost will probably be greater.

Some surgeons might be angry because of the need for additional time and effort and the reduced margin for error. Many surgeons intuitively make a distinction between respecting the patient's

refusal of transfusions and following the patient's request to have the surgery under restrictive conditions. Philosophers distinguish negative and positive rights. Negative rights are claims to be left alone; they protect patients from unwanted interventions on their bodies. Positive rights require others to act in certain ways. Negative rights are generally considered stronger than positive rights. Thus, it makes sense to grant patients a strong right to refuse unwanted interventions but to permit much weaker claims to specify how surgeons carry out their work.

Faced with requests to carry out operations with specific restrictions, surgeons generally have a legal right to decline to operate and to transfer care to another surgeon. In many cases a more fruitful approach is to consider how to minimize additional risks from withholding transfusions. Use of cell savers, hemodilution, and administration of erythropoeitin might reduce perioperative risk (14). Moreover, surgeons should keep in mind the ethical ideal of putting the patient's best interests paramount. A skilled and experienced surgical team offers the patient the best chance at a favorable outcome.

In some cases the patient expresses objections to certain aspects of the proposed operation only because the physician brings up the issues.

CASE 38.3 Patient refusal of emergency colostomy.

A 74-year-old man is admitted to the hospital with an acute abdomen. He is found to have free air under the diaphragm. The surgeon believes that the patient has perforated a peptic ulcer or a carcinoma of the colon. The surgeon explains that if the perforation is in the colon, she will perform a colostomy, which might not need to be permanent. The patient adamantly refuses a colostomy. "A friend had one and had one complication after another. He was so ashamed of that bag. I'd rather be dead than go through that humiliation." There is no time for the patient to talk to people who have adapted well to a colostomy. Technically, an end-to-end anastamosis is possible, but it has a much higher risk of complications.

The surgeon consults a colleague about the case. He says, "In an emergency I never discuss the details of the surgery. All that the patient needs to know is that he needs an operation to save his life and that the risks of surgery are small compared with the alternatives. Too much information can be dangerous because there is no time to correct misunderstandings. All this discussion about a colostomy is probably moot. Chances are he'll have a perforated ulcer. Even if he perforated his colon, you might be able to take the colostomy down later. I wouldn't do an end-to-end anastamosis. How would you justify it at a morbidity and mortality conference if he got a complication?"

In Case 38.3 the ethical dilemma is that the patient might be making an irreversible decision that he would greatly regret later. The surgeon believes that the patient's refusal is based on an unrealistic appraisal of a colostomy. In elective situations most patients can be persuaded to accept a colostomy, but in an emergency there is no time for extended discussions. A surgeon dedicated to acting in the patient's best interests would want to do the less risky operation, knowing that most patients adapt to a colostomy. From this perspective, it would be terrible if the patient refused surgery because of an outcome that might not happen or might be only temporary. The colleague's concern about the morbidity and mortality conference is not just a desire to avoid personal criticism; the professional standard of care is based on what a reasonable surgeon would do under the circumstances.

In contrast, a surgeon dedicated to patient autonomy will respect the patient's refusal of colostomy even if that decision might not be fully informed. From this viewpoint, even if the operation were skillfully performed and successfully treated the perforation, it would be tragic if the patient had to live with a mutilation of his body that he did not consent to. A patient's preferences about therapy depend not only on the likelihood of survival but also on the surgery's nature and the quality of life afterward (15,16). A patient might consider a colostomy so unacceptable that he would rather die than have the operation.

The surgeon in Case 38.1 has several options. One option is to refuse to operate unless the patient agrees to a colostomy if needed. However, this option might leave the patient worse off than having an end-to-end anastamosis. Also, if the on-call surgeon declines to operate, it might be difficult to find a colleague to take over the case without delay.

A better approach is to try to persuade the patient to accept the colostomy. This can often be done despite severe time constraints. The surgeon can ask the patient to talk his decision over with

his family, friends, primary care physician, or the chaplain, and the surgeon could explain to them why a colostomy is preferable. In addition, the surgeon might be able to persuade the patient by paradoxically giving him control. "If you decide that you won't accept the colostomy after talking to your family and your primary care doctor, I'll agree to do the surgery in the other, riskier way. I won't force you to have an operation you don't want. But before you decide, I'd like to understand better what about the colostomy troubles you. I'd also like you to understand why I think the colostomy is the best operation for you." If persuasion fails, it is ethically appropriate for the surgeon to agree to do an end-to-end anastamosis, based on the patient's informed decision.

In trying to persuade patients, some surgeons might be tempted to misrepresent what they will do in the operating room. For example, they might say they will try to do an end-to-end anastamosis if possible even though they actually intend to do a colostomy. For reasons discussed in Chapter 6, such misrepresentation is problematic and undermines both patient trust and the physician's integrity.

In summary, the unique clinical circumstances of surgery impose special ethical obligations on surgeons regarding informed consent, decisions not to operate, and patient requests to carry out the operation in certain ways.

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CHAPTER 39

Ethical Issues in Obstetrics and Gynecology

Ethical dilemmas in obstetrics and gynecology are particularly difficult because care for a pregnant woman and care for her fetus are inextricably linked. Furthermore, decisions about reproduction and sexuality rest on values that are intensely private but often socially contested.

HOW ARE ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY DIFFERENT?

REPRODUCTIVE HEALTH IS HIGHLY PERSONAL, BUT THIRD PARTIES SEEK TO INFLUENCE IT

Decisions in obstetrics and gynecology involve intimate and personal topics, such as sexuality, reproduction, and childrearing. Many women want control of their reproductive decisions and have strong preferences in family planning and childbirth. At the same time, public leaders and religious groups might hold strong views regarding children, family, and women's appropriate role. These third parties might seek to shape women's decisions about reproductive health. Currently, debates over abortion in the United States are passionate and highly politicized. On the one hand, some seek to reaffirm traditional attitudes toward women, reproduction, and sexuality, and on the other hand, feminist critics assert that society and physicians exercise inappropriate control over women through policies regarding reproductive health care. Some women also believe that doctors and society have transformed the experience of pregnancy and childbirth into an overly technological and medicalized procedure.

REPRODUCTIVE HEALTH INVOLVES PHILOSOPHIC QUANDARIES THAT SCIENCE CANNOT RESOLVE

Decisions about reproduction inevitably raise philosophic or religious questions that science cannot resolve.

- Is the fetus a person with moral and legal rights?
- When does personhood begin: at conception, viability, birth, or some other time?
- Does the pregnant woman have an ethical right of reproductive liberty that encompasses a right to abortion?

Theologians, philosophers, public officials, and the public have debated these conundrums without reaching agreement or common ground. Consensus is unlikely to emerge, and public policies need to be developed despite deep disagreements.

NEW REPRODUCTIVE TECHNOLOGIES RAISE UNPRECEDENTED DILEMMAS

Assisted reproductive technologies (ARTs) allow pregnancy to occur in unprecedented ways. With ARTs and gamete donation, different persons can fill the roles of genetic, gestational, and childrearing parents. Dramatic dilemmas have arisen over the disposition of frozen embryos after a couple has separated, ART for postmenopausal women, and "surrogate motherhood," in which the gestational mother has no genetic link with the fetus and will not raise the child after birth. Such dilemmas force people to reconsider fundamental, often unspoken beliefs about parental responsibility and roles.

THE OBSTETRICIAN MIGHT HAVE TWO PATIENTS, THE PREGNANT WOMAN AND THE FETUS

Fetal movements and fetal heartbeat can be visualized with ultrasound and other imaging techniques. Doctors can diagnose many conditions in utero, such as congenital abnormalities or fetal distress. Furthermore, physicians can treat the fetus through interventions on the mother, such as prenatal vitamins, tocolytic agents in premature labor, corticosteroids in prematurity, and fetal blood transfusion for Rh isoimmunization. In light of this ability to diagnose and treat fetal disorders, it seems reasonable to consider the fetus a patient, along with the pregnant woman, provided that she intends to carry the fetus to term and presents for prenatal care (1). Thinking of the fetus as a patient helps prevent inadvertent injury to the fetus by reminding physicians and pregnant women to consider how care for the woman might affect the fetus (2).

Everyone hopes that children will be born healthy. It is tragic when a child is born with a serious preventable illness or congenital anomaly. The pregnant woman has some moral responsibility to take steps to reduce harm and provide benefit to the child who will be born (3). Physicians have a responsibility to represent the interests of such future children, who cannot represent themselves. These moral responsibilities are based on the desire to prevent harm to children who will be born; they do not require a belief that the fetus is a person with rights (3).

The idea that the fetus is a patient is limited by the fact that interventions directed to the fetus are also interventions on the pregnant woman that might cause side effects in her or affect other aspects of her life (2). In premature labor terbutaline causes tremor and anxiety in the pregnant woman. Long-term bed rest for premature labor might prevent the pregnant woman from caring for her other children or working at a job that supports her family. Most pregnant women accept side effects, inconvenience, and disruption of their life for the sake of the child who will be born. However, pregnant woman need not adopt every intervention that might benefit the fetus, regardless of the degree of benefit, risks, or impact on her life. Responsibilities to a fetus who will become a child have limits; logically they should not exceed responsibilities that parents have to living children (4). Parents are not obligated to provide all potentially beneficial interventions to children after birth or to minimize all harms to them.

INFORMED CONSENT IN OBSTETRICS AND GYNECOLOGY

Several situations in obstetrics and gynecology raise particular ethical issues regarding consent.

PROVISION OF INFORMATION ABOUT FAMILY PLANNING AND ABORTION

Some physicians have strong moral and religious objections to these interventions (5). They believe it would violate their conscience to write a prescription for birth control or perform an abortion. Institutions should make reasonable accommodations to conscientious objections, and patients should be referred to facilities that provide care (see Chapter 24).

REPRODUCTIVE HEALTH FOR ADOLESCENTS

Girls under 18 years of age, who are often sexually active, might seek care for contraception, sexually transmitted diseases, or pregnancy. Many people believe that allowing minors to obtain such care without parental consent undermines family values and encourages promiscuity and irresponsibility.